In the Supreme Court

Appeal from the Calhoun County Circuit Court
Hon. James C. Kingsley, Circuit Judge

Estate of **DENNIS J. HALLORAN**, Deceased, by **EILEEN HALLORAN**, Temporary Personal Representative,

Plaintiff-Appellee,

Supreme Court No. 121523

v

RAAKESH C. BHAN, M.D., CRITICAL CARE PULMONARY MEDICINE, P.C.

Defendants-Appellants

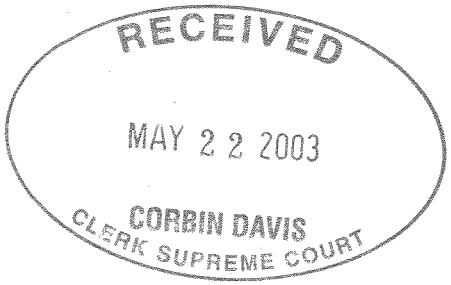
and

BATTLE CREEK HEALTH SYSTEMS,

Defendant.

Brief on Appeal - - Defendant Battle Creek Health Systems

ORAL ARGUMENT REQUESTED



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STATEMENT OF JURISDICTION

The Court of Appeals exercised jurisdiction over this matter pursuant to MCR 7.203(B)(1), by granting Plaintiff's application for leave to appeal. Following an unpublished opinion by that body, Defendant-Appellant's application pursuant to MCR 7.302 was accepted, and this Court directed the parties to brief three specific issues, as authorized under MCR 7.302(F), by an Order dated March 25, 2003.

STATEMENT OF QUESTIONS PRESENTED

ISSUE I. **Is a Standard of Care Expert Witness Qualified Under MCL §600.2169(1)(a) to Present Testimony against a Defendant Physician where the Proffered Witness does not Possess the Same Board Certification as the Defendant Physician?**

Plaintiff-Appellee answers: Yes.

Defendant-Appellant answers: No.

Defendant answers: No.

The trial court answered: No.

The Court of Appeals answered: Yes.

ISSUE II. **Does Proper Construction of the Word "Specialty" in the First Sentence of MCL §600.2169(1)(a) Require Reference to the Speciality in which a Defendant Specializes, Rather than the Specialty Being Practiced at the Time of the Occurrence?**

Plaintiff-Appellee answers: No.

Defendant-Appellant answers: Yes.

Defendant answers: Yes.

The trial court answered: Yes.

The Court of Appeals answered: No.

ISSUE III. **Does Proper Construction of the Phrase "That Specialty" in the Second Sentence of MCL §600.2169(1)(a) Require Reference to the Specialty in which a Defendant is Board Certified, Mandating a Matching of Both Specialty Certification and Primary Board Certification?**

Plaintiff-Appellee answers: No.

Defendant-Appellant answers: Yes.

Defendant answers: Yes.

The trial court answered: Yes.

The Court of Appeals answered: No.

STATEMENT OF MATERIAL PROCEEDINGS AND FACTS

For ease of review, this heading will be divided into four sections, summarizing the medical background leading to this malpractice action, the procedural history below, the opinion and order of the trial court and the opinion of the Court of Appeals.

Medical Background

On September 30, 1994, after several days of heavy drinking, Dennis Halloran, deceased, presented to the emergency room at Defendant Battle Creek Health System (hereinafter BCHS) at 1:00 p.m. His chief complaints included cirrhosis of the liver, increased shortness of breath, increasing stomach girth, upset stomach and weakness. The doctor, the emergency room physician, diagnosed him with cirrhosis and liver failure. Dr. McDonnell also noted that, in May of 1994, Mr. Halloran was to return to the VA in August, but failed to keep this appointment. In addition, he had been prescribed Aldactone by the VA, but had not taken this medication in four months. Dr. McDonnell noted that although Mr. Halloran looked chronically unhealthy, he did not appear to be in any acute distress. The patient was placed on Demerol, and at 4:00 p.m., was seen by Defendant-Appellant Dr. Bhan (hereinafter Dr. Bahn), who had been called in by Dr. McDonnell. The patient was transferred from the emergency room at 4:30 p.m.

Dr. Bhan first examined the patient in the emergency department and noted that Mr. Halloran had hepatic failure, possible cirrhosis, severe ascites and thrombocytopenia, leukopenia, coagulopathy, all of which were most likely caused by liver failure. Dr. Bhan planned to obtain a liver profile and started the patient on vitamin K, IV, and a low-protein diet. He also placed Mr. Halloran on Aldactone and Bumex, IV, diuretics intended to address the bloated condition. A paracentesis was planned if abdominal discomfort continued, but Dr. Bhan intended to wait until the next morning to allow for the diuretics to work–particularly as the lab results raised risk factors as to a bleeding event if paracentesis was immediately pursued.

Mr. Halloran was then admitted to the hospital under Dr. Bhan's orders, and monitored by the nurses in compliance with those orders. His nausea had subsided by 7:00 p.m. Thereafter, two attempts were made to insert a Foley catheter, because he was unable to void. While these attempts were unsuccessful, Dr. Bhan was aware of that fact. Mr. Halloran was again seen by Dr. Bhan at 10:00 p.m., and was continuously monitored from 11:45 p.m. until 1:20 a.m. It is this time frame wherein Dr. Bhan recalls being called approximately "every ten minutes" by the night nursing staff. Mr. Halloran complained of pain and was given Demerol every three hours, as ordered by Dr. Bhan. He saw the patient at 1:40 a.m. and ordered him transferred to the ICU. Mr. Halloran coded shortly thereafter. Resuscitative efforts were attempted, but were unsuccessful, and the patient expired approximately twenty minutes later.

Procedural History

Plaintiff filed the trial court action on September 16, 1998, as Temporary Representative of the Estate of Dennis Halloran, deceased. She named three parties, including Dr. Bhan, Critical Care Pulmonary Medicine, P.C. (the doctor's business practice) and BCHS. The complaint alleged negligent treatment by Dr. Bhan, and sought recovery against his employer as well. BCHS is involved solely due to purported vicarious liability for Dr. Bhan, and no independent allegations of negligence by the hospital's personnel have been pled.

In compliance with statutory malpractice requirements, Plaintiff supplemented her filing with an affidavit setting forth the merit behind the lawsuit. The document was signed by Thomas Gallagher, M.D.. During the course of discovery, it was revealed that the doctor, a specialist in critical care medicine, did his residency training in anesthesiology and obtained his primary board certification from the American Board of Anesthesiology. He was neither board certified nor board eligible in internal medicine, and had never trained as an internist. This information was significant as Dr. Bhan was board certified in internal medicine. Further, the doctor testified

during his discovery deposition that his practice was devoted fairly evenly between critical care and internal medicine.

Based upon the above information, Dr. Bhan filed a motion, on or about November 16, 1999, to strike Dr. Gallagher. The motion argued that, given the differing primary board certifications, Dr. Gallagher was not qualified to serve as an expert witness. The defendant hospital joined in the request, which was granted at a hearing on November 22, 1999. On December 21, 1999, an order in that regard entered. It is this order which Plaintiff appeals.

Opinion and Order of the Trial Court

The December 21, 1999 order (**Exhibit A**; **Appendix pp83a-84a**) is not particularly detailed, and indicates that the motion to strike the expert "is granted for the reasons stated on the record." Judge Kingsley also adjourned trial to allow Plaintiff the opportunity to seek appellate review. An understanding of the judge's decision requires reference to the transcript of the hearing. Early on, the discussion turned to whether the court should "look to the certification of subspecialty" with the trial judge noting that there were "differing certification bodies here" but asking whether the subspecialty was an adequate match (**Tr., page 4; Appendix p66a**). After discussion with co-defense counsel, the focus was narrowed to whether the lack of certification in internal medicine disqualified the expert. Plaintiff's counsel argued that the apparently matching specialization in critical care was adequate to override the board certification provisions. (**Tr., page 9; Appendix p71a**). The court inquired as to how to address board certification when the speciality at issue did not have a primary board. (**Tr., pages 10-11; Appendix pp72a-73a**.) Judge Kingsley acknowledged his concern over the fact that Dr. Bhan had admitted, in his answer to the complaint, that he was a critical care specialist. (**Tr., page 14; Appendix p76a**.)

The trial judge announced his holding:

> I am going to narrowly construe the statute, and in doing so I would agree with (counsel's) analysis that the legislature intended to refer to primary specialties which offer board certification. Critical care is a subspecialty. The American Board of Anesthesiology, for example, offers that subspecialty, but I'm going to construe the legislative language narrowly as referring to primary specialties. And Dr. Gallagher's primary speciality is not the same as that of Dr. Bhan. Therefore, the motion is granted. (**Tr., page 16-17; Appendix pp78a-79a**.)

Following this decision, a timely application for leave was filed, and the Court of Appeals elected to hear the matter. The trial judge was reversed.

Opinion of the Court of Appeals

The March 8, 2002 opinion (**Exhibit B; Appendix pp 86a-91a**)was signed by Judges Fitzgerald and Markey. Judge Hoekstra authored a dissent. The majority opinion noted that both the defendant and the expert had what it labelled as matching critical care certificates, granted by differing primary boards. The opinion interpreted the record as indicating that the "parties agree that no separate board certification exists for critical care medicine" (the parties agree only that no separate *primary board* exists for critical care.) The majority then noted that a certificate of added qualifications may be issued by a primary board.

The opinion offers the assertion that Dr. Bhan "admitted that he was practicing critical care medicine" at pertinent times. It should be noted that this "admission" came in the context of a response to an allegation of Plaintiff's complaint. At paragraph 6) **(Appendix p 14a)**, Plaintiff asserted:

> That Defendant Raakesh C. Bhan is and was at all times relevant hereto a medical doctor licensed to practice medicine by the State of Michigan and in his care of Plaintiff's decedent, was practicing critical care medicine in which he is and was at all times relevant hereto board certified.

To the extent that Dr. Bhan has acknowledged that he was practicing critical care medicine, he has also acknowledged that, in Plaintiff's own words, he was "practicing critical

care medicine in which he is . . . board certified." By admitting paragraph 6, Dr. Bhan was acknowledging that he is a board certified critical care specialist.

The majority summarized the background and argument before the trial court, and then foreshadowed its holding:

> Plaintiff further argues that the last sentence of subparagraph (a) of subsection (1) does not apply to this case because the subspecialty at issue, critical care medicine, does not have a primary board of medicine offering certification. We agree.

The Court of Appeals specifically relied "on this Court's analysis and holding in the recent opinion of" *Tate v Detroit Receiving Hospital, 249 Mich App 212; 642 NW2d 346 (2002).* The opinion acknowledged that *Tate* involved a defendant who was boarded in several specialties, and an expert who was boarded in one of those (internal medicine), which was the specialty most closely related to the patient's medical condition . This factual parameter, however, was then ignored. The opinion continued with a summary of the discussion, in *Tate,* of why the operative specialty would relate to the field of medicine at issue "at the time of the occurrence that is the basis for the action". This analysis was applied to the present claim.

The majority noted that the action "involves critical care medicine and not other specialties" which apply to the Defendant. (In the process, the board certification was implied to be a speciality which should be treated the same as any other certification, rather than as a primary credential which authorized pursuit of additional credentials.) The majority wrote that there was no dispute that both Dr. Bhan and the expert were "certified in critical care medicine." The opinion held that the lack of board certification in internal medicine was "irrelevant" because Plaintiff's allegations did not involve treatment "by defendant acting as an internist." (In the process, the appellate court made the assumption that, once Dr. Bhan studied critical care medicine, he was no longer in internist.) Based upon *Tate*, board certification in internal

medicine was "unrelated". Therefore, the second sentence of MCL §600.2169(1)(a), which references board certification, applied only if the speciality at issue was subject to a primary board. "Because there is no board certification for critical care medicine, the last sentence of §2169(1)(a) does not apply to the present case." Plaintiff's expert was held to possess a matching specialty and to be qualified, and the trial court was reversed.

ARGUMENT

A. Introduction.

The action below presents a forum for discussion of the expert witness requirements of MCL §600.2169. The trial court action presents a defendant and an expert witness with apparently matching specialty credentials, against the background of education and certification by differing primary boards. This Court has identified three specific questions to be addressed. Those topics, while distinct, also share many common elements. Therefore, this document will begin with a combined analysis applicable to all three questions, followed by specific argument as to each. The format will consider the standard of review, identify pertinent statutory language, discuss the trend toward specialization in modern medicine, consider the legislative purpose behind MCL §600.2169, evaluate the Court of Appeals precedent leading to the present debate[1] , and the Court of Appeals reliance on that decision below. Each of the three arguments specified by this Court will then be individually addressed

B. Standard of Review.

The present matter involves the trial court's decision to strike an expert witness. Such decisions are left to the discretion of the trial court, and should not be overturned absent an abuse of discretion. *Tate v Detroit Receiving Hospital, 249 Mich App 212; 642 NW2d 346 (2002).* The analysis also involves interpretation of the terms of MCL §600.2169. "Questions of statutory interpretation are reviewed *de novo* by this Court." *Roberts v Mecosta County General Hospital, 466 Mich 57, 62; 642 NW2d 663 (2002); McDougall v Schanz, 461 Mich 15; 597 NW2d 148 (1999).*

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[1] *Tate v Detroit Receiving Hospital, 249 Mich App 212; 642 NW2d 346 (2002).*

C. Pertinent Provisions of MCL §600.2169.

MCL §600.2169(1)(a) provides in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> > (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

D. The Practice of Medicine is Specialized.

An inescapable reality of modern life is that the practice of medicine has become increasingly complex and specialized. This trend reflects incredible advances in the ability to treat illness, and has been of great benefit to society. However, those with a nostalgic bent can only look back fondly on the days when everyone went to the same local doctor, who treated ear infections, ingrown toenails and everything in between. Rather, the ever-growing understanding of the various medical fields requires extensive and specialized training, in order to provide a patient with the full spectrum of benefits available from the modern healthcare system.

1. Physicians Specialize Based Upon Educational and Practice Experience.

Specialization begins with the concept of board certification, which is nothing new. The American Board of Medical Specialties serves as an umbrella organization for the various boards, and publicizes information about is members. Ophthalmology was the first body to issue formal certification, beginning in 1916. A number of formal certifications were issued in the 1930's, including both of those at issue, internal medicine (1937) and anesthesiology (1938).

Presently, there are a total of 24 recognized primary boards. (**Exhibit C**, ABMS approved board certificates.)

Certification in various subspecialties is also a well-established reality. Some of the various boards (not all) issue certifications in additional areas. Both the number and type of credentials offered by a particular board vary markedly. The oldest board, ophthalmology, offers none. Pediatrics offers as many as 18. Internal medicine lists 17, while anesthesiology permits only two. The critical care subspecialty at issue herein is granted, in at least some fashion, by five boards. In addition to the internal medicine and anesthesiology, the obstetrics and gynecology board offers a certificate in critical care medicine, while the pediatrics board offers pediatric critical care medicine and the surgical board offers surgical critical care. As for a time frame, subspecialty certificates began in the 1970's, with a significant expansion through the 1990's. Critical care was approved by both the ABA and the ABIM in 1985, with certificates issued by the former in 1986 and the latter in 1987. (**Exhibit D**, ABMS approved subspecialty certificates.)

Given the variations on critical care, that subspecialty has developed its own society. A listing of the members of its editorial board provides additional evidence of the specialized nature of modern medicine, and critical care. Science editors come from the fields of anesthesiology, pediatrics and medicine. Specific section editors are necessary to address neurologic critical care and pediatric critical care. Senior editors practice in surgery, medicine, pediatrics and intensive care. (**Exhibit E**, critical care medicine editorial board)

2. Board and Specialty Certification Reflect Particularized Educational and Practice Experience.

Certification in a medical field is not granted at random, simply because someone requests it. Rather, specific training and actual practice experience requirements must be

satisfied. Medicine is highly complex, and the uniquely specialized skills of a particular field require repeated observation and practice under supervision to master.

As would be expected, each primary board has its own set of requirements. The ABMS notes that most boards have some form of initial specialty training and all have advanced specialty training. Each also imposes a written exam, and many also require an oral exam. (**Exhibit F**, ABMS requirements for general certification.)

Board certification is not a one-time evaluation which is then forgotten, much like a college calculus exam is for many. Beginning in the 1970's, and spreading widely in the 1990's, most of the various boards implemented a plan of re-certification. Those who have such a plan require a written examination, and many have imposed continuing medical education requirements. (**Exhibit G**, ABMS re-certification table.)

A review of information by the ABA reveals the qualifications necessary to become boarded in anesthesiology. "An ABA diplomate is a physician who provides medical management and consultation during the perioperative period, in Pain Medicine and in critical care medicine." Further, the physician is qualified "to carry out the entire scope of anesthesiology practice." (**Exhibit H**, ABA description of anesthesiology.) Specific certification requirements mandate that "the candidate shall be capable of performing independently the entire scope of anesthesiology practice" after having studied "the Continuum of Education in Anesthesiology." This continuum includes a base year in one of a variety of different programs, followed by three years of "approved training in anesthesia." Year one "consists of experience in basic anesthesia training, subspecialty anesthesia training and advanced anesthesia training." This includes "basic and fundamental aspects of the management of anesthesia". The second year focuses on more detailed areas including sub-discipline rotations through obstetric, pediatric, cardiothoracic, regional and outpatient anesthesia, as well

as neuroanesthesia and pain management. A third year focuses upon "progressively more complex training experiences and increased independence and responsibility for the resident." This training is mandatory prior to sitting for the ABA board exam, which requires that "the applicant shall be capable of performing independently the entire scope of anesthesiology practice" and present evidence of satisfactory completion of the entire continuum of education. (**Exhibit I**, ABA primary certification.)

The ABA also has specific requirements for subspecialty certification in critical care medicine. In addition to being able to independently perform "the entire scope of anesthesiology critical care medicine", the candidate must be "a diplomate" of the ABA, have "fulfilled the requirement of the continuum of education in critical care medicine as defined by" the ABA and have passed the ABA's critical care medicine exam. The continuum of education is specifically described as 12 months of full-time training "in an anesthesiology critical care medicine program". The applicant must perform "independently the entire scope of anesthesiology critical care medicine practice" and be certified by the ABA. (**Exhibit J**, ABA subspecialty certification in critical care medicine.)

Just as with anesthesiology, the ABIM has its own particularized requirements. According to the Board's summary of frequently asked questions, the certification exam focuses approximately 75% on "traditional specialities of internal medicine" while the remaining 25% "are designated to other relevant areas including allergy/immunology, dermatology, gynecology, neurology, ophthalmology, and psychiatry. Test settings range from "the intensive care unit to the nursing home." A chart indicates a total of 15 primary content areas and 11 cross-content areas. (**Exhibit K**, ABIM frequently asked questions.) Further information regarding general certification in internal medicine includes the credentialing requirements, which mandate a 36 month residency including at least 30 months "in general internal medicine, subspecialty internal

medicine, critical care medicine, geriatric medicine, and emergency medicine." (**Exhibit L**, ABIM primary examination booklet.)

The ABIM also defines specific criteria for added credentials in critical care. Three different "pathways" are available, including a two year fellowship "in a sub-specialty of internal medicine" and a year of "accredited clinical fellowship training in critical care medicine," or "two years of accredited fellowship training in critical care medicine" or a two year fellowship in "advance general internal medicine that includes at least six months of critical care medicine." The ABIM also offers a program by which certain board certified neurologists may obtain a critical care certificate if suitable training is completed. (**Exhibit M**, ABIM specialty examinations booklet.)

Three other primary boards also offer some form of certification in critical care. A review of the requirements of these boards adds to an understanding of the differing educational and practice experiences which can form the basis for critical care specialization. The American Board of Obstetrics and Gynecology offers a certificate in critical care labeled the same as those offered by the ABA and the ABIM. However, in order to obtain the primary board which is a prerequisite to eligibility, an OB/GYN "goes through four years of specialized residency training in areas dealing with pre-conceptional health, pregnancy, labor and childbirth, postpartum care, genetics, genetic counseling and prenatal diagnosis. Training in gynecology also covers women's general health, including care of reproductive organs, breasts and sexual function." Certification in critical care requires that the applicant be board certified by the ABOG and have completed 12 months of education in critical care "in a program fulfilling the requirements of The American Board of Surgery for Surgical Critical Care or the requirements of The American Board of Anesthesiology for Critical Care Medicine." (**Exhibit N**, ABOG publications.)

The American Board of Pediatrics offers general certification after "three years of training in pediatrics" involving "the care of children and adolescents in hospital and outpatient settings." A two-day written examination covers "all aspects of health care for infants, children and adolescents." The board offers speciality certification following completion of an approved program in "pediatric critical care medicine." The pediatric board allows a board certified anesthesiologist to take two years of fellowship training in pediatric critical care and then apply for specialty certification. (No such arrangements are in place with the ABIM.) (**Exhibit O**, ABP publications.)

The American Board of Surgery describes the discipline as "having a central core of knowledge embracing anatomy, physiology, metabolism, immunology, nutrition, pathology, wound healing, shock and resuscitation, intensive care and neoplasia, which are common to all surgical specialities." A board certified surgeon "has acquired during training knowledge and experience related to" nine "essential content areas" including surgical critical care. The Board offers separate certifications in surgical critical care, vascular surgery, pediatric surgery and surgery of the hand. (**Exhibit P**, ABS documents.)

That education and experience are significant to the practice of critical care, is further shown by a review of documents put out by the Society of Critical Care Medicine. This body lists a number of different medical specialities, including, in addition to anesthesiology and internal medicine, pharmacology, emergency medicine, pediatrics, surgery, and a variety of other non-physician specialties such as nursing. The internal medicine section is described as the largest portion of this society. "Internal medicine is the branch of medicine that diagnoses and non-surgically treats diseases affecting the internal organs of the body." The section "provides a forum . . . on issues of importance to internal medicine intensivists." The anesthesiology section of the society sponsors an award which is offered only to "an anesthesia-based intensivist." "The

mission of the anesthesiology section is to represent, promote and educate anesthesiologists/intensivists" and "seeks to help educate non-anesthesiologists/ intensivists regarding the value and role of the anesthesiologists/intensivists within the specialty of critical care medicine." The society offers lists of accredited critical care programs under both internal medicine and anesthesiology. Thirty-three separate programs exist for the former, while 52 programs, some at similar universities but most at entirely different institutions, are available for the latter. (**Exhibit Q**, SCCM documents.)

3. The Standard of Care Involves Two Questions Including Whether a Physician is Qualified to Treat the Patient and, if so, the Applicable Standard Based on That Physician's Educational and Practice Experience.

One of the consequences of the increasingly specialized knowledge and equipment available to physicians is that the standard of care necessarily presents a two-stage analysis of any patient. A physician must first decide if he or she, based upon experience and training as well as available facilities, is qualified to handle the situation, or whether a consultation or transfer is needed. The decision is simple when the presenting complaints are either clearly within or clearly outside of the doctor's area of expertise. However, circumstances frequently arise wherein a physician must make a judgment call on whether or not more specialized help is needed. This decision itself is frequently the subject of a malpractice action, for failure to obtain the appropriate consultations and/or for performance of procedures outside of the doctor's area of expertise. It is also one aspect of the standard of care.

After a decision to either treat or refer the patient has been made, the standard of care is then appropriately based upon that doctor's skill level, as defined by training and experience. Two observations need be made. First, a specialist would, by definition, have more advanced and particularized knowledge as to a given situation. A prime example would be an emergency department presentation for chest pain. If it were determined that it was within the standard of

care for an emergency medicine physician to handle a particular cardiac presentation, it would be unrealistic to then hold the emergency medicine physician to the standard of a board certified cardiologist.

Second, the applicable standard of care for a given physician is not always just a question of who has more knowledge on a given subject. Rather, differing fields of medicine may approach a particular problem from an entirely different perspective. One approach may be better than another in some circumstances and not in others. Differing approaches may be of equal benefit, or the benefit may be subject to ongoing debate.

If the various fields, each with their lengthy and specific training requirements for board and subspecialty certification, did not lead to differing perspectives on some occasions, there would be no point in their existence in the first place. The concept of specialization cannot be recognized as a reality without accepting the necessary corollary that specialization matters, and that the import comes from the specific training and experience which leads to the specialty credentials. This background must be factored into the standard of care.

E. MCL 600.2169 was Enacted to Require that Expert Witnesses be Qualified in the Applicable Standard of Care.

The 1993 amendments which included MCL §600.2169a(2) were part of a general tort reform package which was passed, in part, to address the skyrocketing cost of health care. This Court recognized "the malpractice crisis facing high-risk specialists." *McDougall, supra.*

That decision upheld MCL 600.2169 as constitutional, and affirmed the exclusion of expert witnesses in two separate cases under the terms of the statute. In the principle case, the plaintiff's expert was board certified in internal medicine, as was the defendant, but had not practiced in the field for some time and was working as a pathologist. The witness was stricken under the pre-1993 version of the statute, which required that the expert "specializes, or

specialized at the time of the occurrence which is the basis for the action, in the same speciality or a related relevant area of medicine or osteopathic medicine and surgery or dentistry as the specialist who is the defendant in the medical malpractice action." *Id at 20.* In the companion case, plaintiff's expert was board certified in internal medicine and gastroenterology, while the defendant was a board certified colorectal surgeon. The expert "testified in his deposition that internists and surgeons follow the same standards of care for the diagnosis of gastrointestinal problems and for the performance of diagnostic procedures such as a sigmoidoscopy." *Id at 23.* Even so, the trial court granted a defense motion to strike the witness under MCL 600.2169.

The analysis by this Court was directed at whether the statute was an unconstitutional intrusion upon the rule-making power of the courts. In the process, the legislative purpose behind MCL 600.2169 was discussed at length,

> This proposal is designed to make sure that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical experience in the subject matter about which they are testifying. In particular, with the malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to ensure that in malpractice suits against specialists the expert witnesses actually practice in the same speciality. *Id at 26.*

The Court wrote that the statute:

> reflects a careful legislative balancing of policy considerations about the importance of the medical profession to the people of Michigan, the economic viability of medical specialists, the social costs of "defensive medicine," the availability and affordability of medical care and health insurance, the allocation of risks, the costs of malpractice insurance, and manifold other factors, including, no doubt, political factors - - all matters well beyond the competence of the judiciary to re-evaluate as justiciable issues. *Id at 29-30.*

In a footnote, the opinion added:

> However dissatisfied the dissent may be with the legislative determination that led to the enactment of §2169, there unquestionably is an extensive record (frequently noted in the dissent) establishing the policy concerns of our Legislature regarding the medical malpractice crisis it believed the state of Michigan faced and the

policy choices that influenced its enactment of §2169 to redress the crisis. *Id at 30, note 19.*

In the process of deciding *McDougall*, this Court also noted a well-established principle, that "the Legislature is authorized to change a common-law cause of action or abolish it altogether". *Id at 30, note 36.* The Court concluded that the statute was "an enactment of substantive law." The opinion held that, in both cases before it, the expert witness had been properly stricken for failure to satisfy, in one case, the specialization requirements and, in the other, the board certification requirements.

The Legislature has provided some direct evidence of the intent behind the expert witness reforms. The House Legislative Analysis Section issued a review of the bills which led to the 1993 enactments. (**Exhibit R**, House Summary.)

> 1986, the legislature enacted a series of reforms aimed at growing concerns about the effect of the medical liability system on the availability and affordability of health care in Michigan. Reforms that specifically addressed medical liability included limiting awards for noneconomic loss (that is, pain and suffering) to $225,000 (with exceptions), specifying qualifications for expert witnesses, constricting the statute of limitations for bringing a medical malpractice lawsuit, providing for the dismissal of a defendant upon an affidavit of noninvolvement, requiring mediation, and requiring each party either to provide security for costs or to file an affidavit of meritorious claim or defense.
>
> Opinion is widespread in the medical community and elsewhere that these reforms have proven inadequate.
>
> * * *
>
> Using survey results and anecdotal evidence, critics of the current system maintain that litigiousness and the high cost of insurance in Michigan drive out physicians, either literally out of state, or out of practice through early retirement. Many other physicians choose to remain in practice, but eliminate costly elements such as obstetrics that carry a comparatively high risk for lawsuits (for example, obstetrical coverage in Detroit costs $134,000 annually for $1 million per occurrence/$3 million aggregate coverage; for $100,000/$300,000 coverage, the annual cost is $63,000). The medical liability climate thus is held at least partly responsible for problems that people in urban centers, and rural areas have in

> obtaining medical care, and responsible for increasing health care costs by forcing physicians to practice "defensive medicine."

The analysis went on to discuss the content of the bills, noting that one of the provisions was intended to "require expert witnesses to be of the *same board-certified speciality or health profession as the defendant*." (Emphasis added.)

> Under the bill each expert witness (not just those in cases involving specialists) would have to have spent a substantial portion of the preceding year in active clinical practice in the same health profession as the defendant or in the instruction of students. If a defendant was board-certified, the witness would have to be, and if the defendant was a general practitioner, the witness would have to either be a general practitioner or instructing students.

[redacted]

internal medicine." Defendants moved for summary disposition under MCL §600.2169, arguing that the expert was not qualified to testify against the defendant, who was "board certified in internal medicine, critical care medicine, and nephrology." The trial court granted the motion.

On appeal, the question was framed as follows:

> Plaintiff essentially argues that when a health professional is board certified in several specialities, section 2169 should be read so as to allow an expert to testify if that expert is board certified in the same speciality being practiced by the health professional at the time of the alleged malpractice. We agree. *Id at 215.*

Tate has been understood by some as establishing a general rule that the operative specialty is always the "specialty being practiced." As will be developed below, *Tate* is properly limited to situations wherein "a health professional is board certified in several specialities (and is practicing in one of those specialities at the time of the alleged malpractice)". This is consistent with the real debate in the case, which was whether, when one specialty was being practiced and had been matched, additional specialization credentials must also be mirrored. To that extent, and no further, *Tate* represents a sound holding. For the same reason, *Tate* is a limited holding distinguishable from the present case.

Tate is best summarized by setting forth extensive excerpts therefrom, as follows:

> Subsection 2169(1)(a) specifically states that an expert witness must "specialize[] at the time of the occurrence that is the basis for the action" in the same specialty as the defendant physician. The statute further discusses board-certified specialists and requires that experts testifying or on behalf of such specialists also be "board certified in that specialty". The use of the phrase "at the time of the occurrence that is the basis for the action" clearly indicates that an expert's specialty is limited to the actual malpractice. Moreover, the statute expressly uses the word "specialty," as opposed to "specialties," thereby implying that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold. Indeed, *McDougall,* 461 Mich. at 24-25, states that "the statute operates to preclude certain witnesses from testifying solely on the basis of the witness' lack of practice or teaching experience in the *relevant* specialty." [Emphasis in original] *Id at 218.*

* * *

> The Legislature enacted §2169 to make sure that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying. In particular, with the malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists the expert witnesses actually practice in the same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns." *Id at 218-219.*
>
> * * *
>
> Certainly §2169 cannot be read or interpreted to require an exact match of every board certification held by a defendant physician. Such a "perfect match" requirement would be an onerous task and in many cases make it virtually impossible to bring a medical malpractice case. Surely the Legislature did not intend to eradicate a plaintiff's ability to bring a meritorious malpractice action against a defendant physician who happens to have board certifications in several different fields. *Id at 219.*
>
> * * *
>
> Thus where a defendant physician has several board certifications and the alleged malpractice involves only one of these specialties, §2169 requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice. *Id at 220.*

2. *Tate* Defined Speciality In Terms of the Type of Medicine Involved at the Time of the Occurrence Because of the Multiple Specialities Involved.

The fact that the *Tate* holding is meant to address only those limited situations wherein a defendant possess multiple specialities and one of those is being practiced can be seen by a focus upon the words used in the second excerpt set forth above. The Court began by noting that the expert witness must specialize "in the same specialty as the defendant physician". However, the opinion then concludes that the phrase "at the time of the occurrence that is the basis for the action" demonstrates "that an expert's specialty is limited to the actual malpractice". This is immediately followed by a reference to the fact that the statute references speciality in the singular, rather than specialities in the plural. This is said to support the proposition that "the

speciality requirement is tied to the occurrence of the alleged malpractice and not unrelated specialities that a Defendant physician may hold."

The underlying assumption, that the defendant was practicing in an area in which he or she was specialized, is further revealed by the third excerpt which discusses the legislative intent behind the statute. The Court notes that "this reform is necessary to ensure that in malpractice suits against specialists the expert witnesses actually practice in the same specialty." It is accurate to say that the expert witness should practice in the same specialty, and possess the same board certification, as the defendant. However, it is inaccurate to assume that the speciality in which the doctor has trained will always be the specialty being practiced at the time of the alleged negligence. Rather, regardless of the type of medicine at issue, the statute was enacted to ensure that "in malpractice suits against specialists the expert witnesses actually practice in the same specialty." The "same specialty" is that of the defendant.

The fourth excerpt provides a clear and direct statement that the holding in *Tate* is limited. The court drafted a rule specifically applicable "where a defendant physician has several board certifications and the alleged malpractice only involves one of those specialities". This is far from a broad rule that primary board certification may simply be ignored when a subspecialty has apparently been matched up, as is the case herein.

The *Tate* court focused upon the fact that the statute "specifically states that an expert witness must 'specialize at the time of the occurrence that is the basis for the action.'" *Tate, supra at 218.* It found that the use of this phrase "clearly indicates that an expert's specialty is limited to the actual malpractice." *Id.* This language applied to a case where the defendant was board certified in multiple specialties, was practicing in one of those at the time of the occurrence, and was matched by the expert witness as to that speciality. It does make sense, in that context, to link the specialty to the occurrence. That the *Tate* court intended this is further

evidenced by further language from the decision, which noted that the statute used specialty in the singular, again "implying that the specialty requirement is tied to the occurrence" and should not be linked to "unrelated specialities" the defendant was certified in. *Id.*

The *Tate* court placed much reliance upon the analysis of *McDougall, supra*. The Court of Appeals focused upon the fact that, in *McDougall*, this Court found that the legislation was intended to exclude experts who lacked credentials "in the relevant specialty." Both *McDougall* and the amendments to MCL §2169 were clearly focused upon ensuring that experts were qualified in the relevant speciality. While *McDougall* did not specifically define the relevant speciality, this Court did write that "this reform is necessary to ensure that in malpractice suits against specialists the expert witnesses actually practice in the same speciality." *McDougall, supra at 25, note 9*. The *Tate* court failed to recognize that this language suggests that the specialty of the defendant should control. This can only be explained by the presence of a defendant with multiple credentials, one of which was involved in the operative occurrence. It is only under those limited facts that *Tate* properly interprets *McDougall* and defines specialty.

3. *Tate* is Subject to Misinterpretation and has been Misunderstood by the Court of Appeals in *Nippa v Botsford General Hospital.*

The *Tate* decision was misinterpreted by the Court of Appeals in *Nippa v Botsford General Hospital 251 MI app 664; 651 NW 2d 103 (2002)*. In the process, that court used language which could be said to support Plaintiff herein, but also announced a decision which generally supports the defense. The case involved an affidavit signed by a doctor who specialized in infectious disease but was not board certified in that field. Of the three doctors alleged to be negligent, two were board certified in infectious disease and one was board certified in general surgery. The Plaintiff attempted to argue that, because only a hospital had been named as a party, and the hospital was not board certified, MCL 600.2169 did not apply. This argument

was rejected, as it would "effectively repeal" the statute, "rendering it nugatory and meaningless, an interpretation that this Court must avoid." *Id.*

In the process of its consideration, the *Nippa* court briefly referenced *Tate*. "The *Tate* court also observed that by its plain terms 'section 2169 requires an expert witness to possess the same speciality as that engaged in by the defendant physician during the course of the alleged malpractice.'" *Id at page 673*. Some consider this to state a general rule applicable to malpractice actions. However this quotes only half of the sentence from *Tate*, which held that "where a defendant physician has several board certifications and the alleged malpractice only involves only one of those specialties," followed by the balance as quoted above.

Nippa otherwise supports the defense view herein. Although the Court of Appeals did offer an interpretation of *Tate* which may be subject to challenge, it also upheld the requirement that the expert witness match the defendant's credentials. In the context of ruling that, even when the hospital was the only named defendant an affidavit and appropriate expert testimony were necessary, the appellate court characterized the legislation as imposing a "requirement that an expert witness share the same board certification as one he intends to testify against." *Nippa, supra at 675*.

G. The Court of Appeals Below (Mistakenly) Relied on *Tate*'s Interpretation of Specialization.

The Court of Appeals below relied upon *Tate* and found that decision to be controlling. "In deciding this case, we rely upon this Court's analysis and holding in the recent opinion of *Tate, supra*." The opinion did note that *Tate* involved an expert certified in and specializing in a single field, while the allegedly negligent physician was board certified in several specialities, including that possessed by the expert. It added that "the medical malpractice occurred during the practice of internal medicine and not during the practice of the other specialties." In spite of

having acknowledged these limitations, the opinion then quoted the *Tate* analysis, to stand for the rule that the controlling specialty should always be based upon the time of the occurrence that is the basis for the action. In the process, it emphasized the *Tate* language that "§2169 cannot be read or interpreted to require an exact match of every board certification held by a defendant physician."

The Court of Appeals repeated the narrowly tailored holding in *Tate*, that it related to situations "where a defendant has several board certifications and the alleged malpractice only involves one of these specialties." It followed with the conclusion that "the alleged malpractice in the instant case that serves as the basis for the action involves critical care medicine and not other specialties in which Gallagher and defendant are certified." This requires the assumption that the board certifications which the defendant and the expert herein possess were, in fact, "other specialities", rather than foundational credentials which led to the certification in the subspecialty. The opinion added that there was "no dispute" that both the defendant physician and the expert were certified in critical care medicine. Again, this assumes the underlying proposition that certification in the subspecialty makes the underlying board irrelevant. In fact, the Court of Appeals specifically went on to state that the lack of "board certification in internal medicine is irrelevant because plaintiff has not alleged malpractice against defendant for treatment rendered by defendant acting as an internist." The specialty was "tied to the occurrence of the alleged malpractice and not the unrelated specialities that the physician may possess." Therefor, "the second sentence of §2169(1)(a) . . . refers to the critical care specialty that serves at the basis for the action and not the specialty of internal medicine." Therefor, the board certification requirement in this sentence "does not apply to the present case."

Judge Hoekstra's dissenting opinion found the reliance upon *Tate* to be misplaced. The fact that Dr. Bhan has been certified by a board "plainly invoked the board certification

provision" of the statute. "I also believe that the majority's reliance upon (*Tate*) is misplaced. *Tate* is distinguishable because, ultimately, the operative board certifications of the two doctors at issue in *Tate* were the same. Here, they are different."

If the Court of Appeals decision herein were treated as a standing rule, board certification provisions in the second sentence of the statute could be ignored if the first sentence was satisfied. However, that sentence requires only that the expert witness specialize in the field of medicine at issue, and makes no reference to certification. Standing alone, the first sentence does not require the expert to be certified by any board, but only to practice in the same specialty. For example, on the facts presented herein, an expert who regularly practiced in critical care would be qualified without ever having taken a certification exam or, for that matter, after having failed any number of exams any number of times. This would render the balance of the statutory language completely nugatory and void any time a plaintiff could argue that he specialty involved at the time of the occurrence did not have a specific primary board. This was clearly not the intent of the legislature, as will be discussed below.

ISSUE I. A STANDARD OF CARE EXPERT WITNESS IS NOT QUALIFIED UNDER MCL §600.2169(1)(A) TO PRESENT TESTIMONY AGAINST A DEFENDANT PHYSICIAN WHERE THE PROFFERED WITNESS DOES NOT POSSESS THE SAME BOARD CERTIFICATION AS THE DEFENDANT PHYSICIAN.

This Court has directed the parties to address three specific issues, the first of which is recited immediately above. After analysis of the dispute or ambiguity leading to this question, this will address whether the board certification provisions of MCL §600.2169(1)(a) must always be applied, or whether they can be ignored when the specialization requirements of the subsection appear to be matched. This approach will include a review of applicable rules of legislative and grammatical construction, a consideration of the languaged used in the subsection at issue, and application of these principles to a practice of medicine which the Legislature was

presented with when the statute was passed. The balance of this brief, under Issues II and III, will then address the extent to which the board credentials of a defendant must be precisely matched by the expert witness.

A. This Question Addresses Whether Board Certification Must Always be Referenced, Over and Above the Consideration of Specialization.

One result of the *Tate* interpretation of the expert witness statute, has been disagreement as to whether the second sentence of §(1)(a), regarding board certification, must always be factored into the examination of an expert's credentials, or, conversely, whether a matching of the specialization requirements in the first sentence allows one to disregard the board certification provisions. This is not a debate which will always, or even frequently, be raised. Usually, the controlling credentials possessed by a defendant are readily apparent and subject to easy discernment. An emergency department physician, board certified in that field and possessing no other specialities, treating an accident victim in an emergency department, would be criticized by a board certified emergency medicine specialist, and no one would suggest otherwise. Similarly, a boarded pediatrician possessed of no other speciality credentials, treating a child during a normal wellness visit, would require a plaintiff to obtain a similarly certified pediatrician. There would be no debate that extra credentials needed to be matched, or that any field other than that in which the defendant was boarded was the controlling factor.

The present dispute arises when a physician possesses multiple credentials. The defendant may have more than one primary board, and/or may be certified in one or more specialities by one or more boards. When a defendant is practicing within one of those specialty areas which lack a primary board, there seems no debate but that the specialization must be matched by the expert witness. The debate herein asks whether, in that situation, the underlying board credentials must also be referenced. Assuming that board certification must be referenced,

a second question is raised. Physicians with differing board credentials may specialize in, and become certified in, a similarly titled sub-field of medicine. The parties debate whether the statute, if it does require reference to a primary board, mandates that the certification come from the same underlying board.

The action herein raises both of the above questions. The defendant, a board certified internist, specialized and was certified in critical care medicine. The expert, a board certified anesthesiologist, was certified in critical care medicine, apparently the same speciality (at least based upon the title). The Court of Appeals below found in favor of Plaintiffs as to the first question, holding that board certification could be ignored. That panel therefore found it unnecessary to address whether, if a board was required, the expert must possess a matching board. Defendants argue herein that critical care certification for an internist is intrinsically different than that for an anesthesiologist, and that the board provisions must e applied, and require an expert certified by the same primary board.

B. Proper Construction of MCL 600.2169(2) Mandates Reference to Board Certification.

When the language of the statute is reviewed in light of rules of legislative and grammatical construction, the mandatory nature of the board certification provisions becomes apparent. Use of "however" to introduce the second sentence, and the employment of an if/then sentence structure demonstrate that this sentence is intended to apply over and above the preceding language of the first sentence. However, the Court of Appeals ignored the second sentence.

1. Applicable Rules of Legislative Construction.

A pair of recent decisions by this Court provide a concise summary.

> An anchoring rule of jurisprudence, and the foremost rule of statutory construction, is that courts are to effect the intent of the Legislature. (Citation omitted.) To do so, we begin with an examination of the language of the statute.

> (Citation omitted.) If the statute's language is clear and unambiguous, then we assume that the Legislature intended its plain meaning and the statute is enforced as written. (Citation omitted.) A necessary corollary of these principles is that a court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself. (Citation omitted.) *Roberts v Mecosta County General Hospital, 466 Mich 57; 642 NW2d 663 (2002).*
>
> When faced with questions of statutory interpretation, our obligation is to discern and give effect to the Legislature's intent as expressed in the statutory language. (Citations omitted.) Undefined statutory terms must be given their plain and ordinary meanings. (Citation omitted.) *Cox v Board of Hospital Managers, 467 Mich 1; 651 NW2d 356 (2002).*

2. Use of "However" Requires Reference to Board Certification.

A compelling factor in proper construction of the language at issue is use of "however" to begin the second sentence of §(2)(a). The statute tells us that specialization credentials must be considered. It then uses "however" to introduce the board certification requirements. A key to proper interpretation is the meaning of "however" in this context. In that regard, rules of legislative construction direct us to the ordinary meaning of the word and the sentence structure. Dictionaries and rules of grammatical construction are acceptable and enlightening sources.

The Random House Dictionary, by Random House, Inc., 1980, defines "however" as an adverb which means "nevertheless or yet" or "to whatever extent or degree" or "in whatever manner or state."

The American Heritage Dictionary, Second College Edition, by Houghton Mifflin Company, 1985, offers a longer description. "However" can be an adverb meaning "by whatever manner or means" or "to whatever degree or extent". It can also be a conjunctive, meaning "nevertheless" or "yet". An example is offered: "*The tickets are expensive; however, we will go.*" This source offers a comment on usage, indicating that the word "is redundant in combination with *but*." An example compares two sentences: "*He had an invitation but didn't go. He had an invitation; however, he didn't go.*"

Webster's publishes a number of different dictionaries. A review of four of its publications provides a broad, representative sampling of definitions. The Merriam-Webster Dictionary was published by Merriam-Webster, Inc. in 1994. "However" can mean "to whatever degree" or "in whatever manner" and can also mean "in spite of that".

Webster's New World Dictionary, by William Collins Publishers, Inc., 1980, offers several variations of "no matter how" and then offers the conjunctive: "nevertheless; yet; in spite of that; all the same: often used as a conjunctive adverb".

Webster's II New College Dictionary by Houghton Mifflin Company, 2001, includes "by whatever manner" followed by "to whatever extent" and then "nevertheless: yet ("It looks like rain; *however*, the picnic is on.")

Finally, Webster's Vest Pocket Dictionary, by Merriam Webster, Inc., 1981, offers a concise definition, including either "to whatever degree or in whatever manner" or "in spite of that".

English grammar texts offer further guidance. One such, Understanding English Grammar by Ronald Wardhaugh, Blackwell Publishers, Inc. (1995), discusses "conjunctive adverbs", such as "*however, moreover*, and *nevertheless*." (page 29) Two examples given are illustrative. First, "*John left; Mary stayed, however.*" Second, "*John left, however, Mary stayed.*" *Id at page 29.* The author describes "however" as relating to the "relationship between the elements that are joined". When the topic is discussed later, the author describes the function as to "join clauses", noting that various positions in the conjoined clause might be used. Another sample is provided: "*He did it; however, he didn't have to do it.*" *Id at page 63.* Further on, in a chapter discussing coordination, conjunctive adverbs are described as being "used to conjoin two clauses" which is "largely a semantic matter rather than a grammatical one in that the second clause adds a further comment on some aspect of the content of the first clause." Yet another

sample sentence is offered: "*He did it; however, he shouldn't have done so.*" *Id at pages 102-103*. Finally, in the glossary, the author describes a conjunctive adverb as a "joining word like *however* or *moreover* with considerable freedom of movement in the second of the conjoined elements". *Id at page 271.*

The University of Michigan Press released English Sentence Structure by Robert Krohn in 1971. That text distinguishes between conjunctions (and, but, or) and sentence connectors (however, therefore, also, etc.)(page 86). In the examples, the author treats "however" as being similar to "but". He offers the sentence: "*Mary was happy, but Alice was very sad.*" He then suggests "use of the sentence connector *however* to join the two sentences" leading to the following: *"Mary was happy. However, Alice was very sad." Id at page 29.* The author follows this with a note: "The meaning of *however* is similar to the meaning of the word *but*. Both are used to indicate that the information that follows is contrary to the information that precedes." This understanding demonstrates both the connective relationship which "however" is used to demonstrate, and the contradictory nature of the comparison being made. Plaintiff herein might wish it were otherwise. *However*, use of the word "however" means that the second sentence qualifies the first.

Another interesting source is The Irwin Law Office Reference Manual, published by Irwin/Mirror Press on behalf of the National Association of Legal Secretaries (1996). The handbook describes "however" as a conjunctive adverb, "used to join two independent clauses" and to provide "a transition between the two clauses." The example offered reads: *"Interest rates seem to be stabilizing; however, no one can predict the future trend."* *Id at pages 40-41.*

3. Use of an If/Then Sentence Structure Requires Reference to Board Certification.

The statutory language at issue includes two sentences, connected by the use of however. Each of those separate sentences uses a similar construction, starting with a condition introduced

by "if" and then stating the restriction imposed by the use of the conditional "if". It is readily apparent that use of this if/then pattern involves the imposition of a condition which must be satisfied.

The usage of "if" is subject to well-established rules. According to The Basic English Handbook by Gilbert H. Muller, published by Harpers College Press in 1978, "if" is a subordinating conjunction which is used to join a dependent clause to the main or independent clause. When a sentence starts with "if", it "signals the start of a subordinate clause that will depend upon an independent clause for the completion of meaning in the sentence. The beginning phrase is subordinate and the latter is the major idea or independent clause." *Id at page 98*. When Understanding Language Grammar, *supra*, is referenced, "if" is described as a subordinating conjunction. *Id at page 28*. According to English Sentence Structure, *supra*, "if" is a subordinator, "used to introduce subordinate clauses, that is, embedded statements." *Id at page 252*. Sentences are built around an if/then relationship are "conditional sentences". *Id.*

A conditional sentence establishes a relationship between the independent and dependent clauses. Satisfaction of the condition is mandatory. In the two sentences of MCL §600.2169(1)(a), two conditional imperatives (if) are joined by a conjunctive (however). Both conditions must be met and the latter sentence must be given full effect in spite of whether the first sentence has been satisfied. Both specialization and board certification are subject to a mandatory condition. The literal terms of the statute require that the expert witness satisfy the first condition and, in spite of specialization, also satisfy the board certification condition.

4. Reference to Board Certification is Consistent with the Realities of Modern Medicine and Legislative Intent.

Board certification is an essential building block in the educational foundation of an ever-growing percentage of the physician population in this country. Specialization is a reality, which

has brought many benefits. In the process, medical malpractice issues such as the appropriate standard of care, and the witness qualified to testify regarding that standard, have become more complex. To ignore the importance of board certification would be to assert that the years spent in increasingly specialized training have no impact upon a physician's knowledge base or approach to patient care. The reality is that training, and periodic re-certification, necessarily produce a training-based approach.

The Legislature clearly recognized that training and education matter. Tort reform was intended to directly address "high-risk specialists" in light of the increasing cost of malpractice litigation and the threat of an increase in defensive medicine. The drafters did not appreciate the complexities which could be found in the language they used, when attorneys devoted their efforts to dissecting the statute in the course of litigating civil claims. However, the language they chose to use, when given a fair reading, expresses a clear intent to recognize the importance of board certification.

C. Proper Construction of MCL 600.2169(1)(a) Mandates Matching of Board Certification.

Once it is established that the board certification provisions of MCL §600.2169(1)(a) must be referenced, there remains a debate as to the full extent that board credentials control. The Court of Appeals below chose to state that the second sentence could completely be ignored, a conclusion which appears erroneous, and therefor did not address whether the board criteria, although not entirely ignored, can be overridden by the specialization provisions of the first sentence.

A proper answer to this question depends upon resolution of two specific questions which are presented by the statutory language. They are, first, which specialty defines the standard of care and, second, whether an expert must match both board and subspecialty credentials. These

are also issues II and III which this Court has directed the parties to brief herein (and in a companion case). Those questions are considered hereafter.

ISSUE II. PROPER CONSTRUCTION OF THE WORD "SPECIALTY" IN THE FIRST SENTENCE OF MCL §600.2169(1)(A) REQUIRES REFERENCE TO THE DEFENDANT'S SPECIALTY, RATHER THAN THE TYPE OF MEDICAL ISSUES INVOLVED AT THE TIME OF THE OCCURRENCE.

A. Issue Presented.

The issue presented under this section is whether MCL §600.2169(1)(a) defines specialty in terms of the field of medicine related to the condition being treated or the specialty in which a defendant is trained and experienced. The former requires an expert trained in the specialty best suited to treat the patient. The latter requires an expert trained in the specialty which the defendant has learned. The Court of Appeals below missed this distinction and held that the phrase "the time of the occurrence" required reference to the type of medicine involved, rather than the credentials of the defendant. This decision was based upon the interpretation that *Tate, supra,* represented a broad definition of "specialty" which would apply to all malpractice situations. The limited applicability of *Tate*, to claims involving a defendant with multiple credentials, was overlooked. The parties herein debate whether the *Tate* analysis applies and, if so, controls.

B. Proper Construction of "Specialty" Requires Reference to the Specialty in Which a Defendant has Training and Experience.

When the language of MCL §600.2169(1) is considered in its entirety, in light of the legislative intent, it becomes apparent that the Court of Appeals below incorrectly extended the *Tate* holding. The result matches neither legislative intent nor modern reality. Those points are addressed below. The defining credentials for an expert are those possessed by the defendant.

1. The Language used Favors Reference to the Defendant's Credentials.

The word specialty, which some would relate to the field of medicine involved at the time of the occurrence, is not used in isolation. Specialty is placed between other words, and variations of the word are used in two other locations in the sentence. All are instructive.

Specialty is used in a phrase requiring "the same specialty as the party" who the expert will testify against. This phrase clearly tells us that the specialty at issue must be the same as something. That something is specifically said to be "the party". While this wording could leave room for construction in situations where a defendant possesses multiple specialities, the basic ground rule, based on the language used, is to start with the specialty of the defendant.

Variations of the root word underlying "specialty" are found in two other places in the sentence at hand. If the defendant "is a specialist" the expert must "specialize" in "the same specialty as the party". Use of "specialist" tells us that the speciality of the defendant is the condition upon which the rest of the sentence hinges. The statute then tells us that the expert must "specialize" which is the equivalent of saying that the expert must "be a specialist". We are thus told that, if the defendant is a "specialist" the expert must also be a "specialist". The balance of the sentence tells us what the expert must "specialize" in, that being "the same speciality as the party". Broken down into less precise and more ordinary language, the sentence basically states that, if the defendant is a specialist, the expert must be a specialist in the same specialty.

The Court of Appeals below placed a different meaning upon the "same specialty". It found that "the expert witness must specialize in that same speciality that serves as the basis for the action." This reads language into the statute which is not present. In essence, the Court of Appeals interpreted the statute to define the operative specialty as "the same specialty as the party (was practicing at the time of the occurrence)". These words were not actually used nor

are they necessary to make the statute workable or give it the intended effect. The language of the statute, when properly read, actually tells us that the "same specialty as the party" is the party in which the defendant "is a specialist".

The Court of Appeals below focused on the language "at the time of the occurrence", and found this to be the controlling phrase. This appears to be what The Irwin Law Office Reference Manual, *supra,* defines as a "restrictive (essential) clause". "A restrictive dependent clause describes or explains the word or idea immediately preceding it. These clauses are essential to the meaning of the sentence and should not be set off by commas." *Id at page 10.* The question is what "the time of the occurrence" restricts. The phrase cannot properly be linked to the earlier use of "specialist" or the later use of "same specialty". The last antecedent rule requires that it be linked to "specialize". Further, the phrase discusses "when" and not "which". Contrary to the decision by the Court of Appeals, "at the time of the occurrence" tells is when the expert must have specialized, and not what type of speciality the Legislature intended.

2. The Language of MCL §600.2169(1)(b) and (c) Favors Reference to the Defendant's Credentials.

This discussion has focused upon §2169(1)(a). Two other subsections follow:

> (b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> > (i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
> >
> > (ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.

> (c) If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> (i) Active clinical practice as a general practitioner.
>
> (ii) Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed.

Subsection (b) tells us that the actual practice experience of the defendant and the expert, during the year preceding the subject occurrence, are relevant to whether the credentials match. The expert must, if the party is a specialist, either (i) practice in "that specialty" or (ii) teach "in the same specialty." It is significant to note that §(b) does not refer to practice or teaching "at the time of the occurrence" but rather "during the year immediately preceding the date of the occurrence" when determining credentialing requirements. It is clear that the focus of the legislation is the specialty regularly practiced by the defendant over a year, and not the field of medicine involved in a particular occurrence. While the Legislators may have expected a specialist to typically practice within his or her specialty (and to be accused of negligence when going beyond one's area of expertise), they did not define the standard of care in terms of the occurrence, but rather the specialty of the defendant.

Section (c) adds another perspective to the analysis. This section tells us that, if the defendant, rather than specializing, is a general practitioner, an expert witness must demonstrate similar active clinical practice or instruction of students in general practice. The statute does not just lower the minimum requirements for an expert, but also imposes a ceiling. A general practitioner cannot be criticized by one who specializes in the area of medicine involved in the subject occurrence, but rather must engage in a general practice. Under this section of the statute, there is no interpretation which allows for "the time of the occurrence" to define the

controlling specialty. If a general practitioner is critiqued based on training and experience, it is logical to expect that the same factors control as one moves up the specialization ladder.

3. Evidence of Legislative Intent Favors Reference to the Defendant's Credentials.

As developed above, the statute was enacted to address a perceived crisis in the cost of health care, in large part contributed to by malpractice claims against high-risk specialists. Among other purposes, the original act in the 80's and the amendments from 1993 were directed at tightening the requirements for expert witnesses. As excerpts of the legislative history revealed, experts were expected to be trained in the same speciality as a defendant. The 1993 amendments specifically deleted the provisions which allowed an expert to be in a closely related field, and required more of an exact match. Clearly, the Legislature was both recognizing the importance of specialized education and practice experience, and tightening the requirement that an expert witness possess a similar background.

4. The Court of Appeals Wrongly Relied on *Tate* Below.

The Court of Appeals below explicitly stated its reliance upon *Tate*, and went on to hold that "[s]imilarly . . . the instant case . . . involves critical care medicine and not other specialties in which (the expert) and defendant are certified." Further, the operative specialty "is tied to the occurrence of the alleged malpractice and not the unrelated specialties that the physician may possess." The specialty in the second sentence of the statute, addressing board certification, "refers to the critical care speciality that serves as the basis for the action and not the specialty of internal medicine." That sentence therefor does not apply.

A first error in the lower court's analysis was failure to recognize that *Tate* was addressing a defendant who possessed multiple certifications, cutting horizontally across the spectrum of various fields of medicine. *Tate* did not involve consideration of the vertical aspect of specialization, whereby a physician first obtains a primary board and then can obtain one or

more speciality boards. *Tate* addressed a situation where one of the specialities at issue was a direct match, both in terms of board and subspecialty, and the issue was whether additional, unrelated speciality credentials must be also be matched.

The present case involves a diametrically opposed situation, with a defendant and an expert who both possess a subspecialty which shares only a name. Each got to that specialty by way of different primary boards and would not be eligible to sit for each other's specialty exam in critical care medicine. The defendant herein does not have board or specialty certification in unrelated areas of medicine. The present case involves a defendant with a single board, and a single specialty certification from that board, and an expert with an alternative primary board. The dissenting opinion recognized this, noting that "*Tate* is distinguishable because, ultimately, the operative board certifications of the two doctors at issue in *Tate* were the same. Here, they are different." As Judge Hoekstra recognized, the defendant's "board certification plainly invoked the board certification provision" of the statute, and must be considered, if not "the defining credential," then at least one of the defining credentials.

A second aspect of this issue perhaps explains why the majority ignored board certification below. The opinion treats both the primary board and the subspecialty as equal, noting that the alleged malpractice "involves critical care medicine and not other specialities" at issue. The majority considers the primary board to be simply another specialty, and finds the board certification in internal medicine to be "irrelevant" because the allegations did not involve "treatment rendered by defendant acting as an internist." The alleged malpractice involved critical care and not "the unrelated specialties" involved. The above analysis requires the underlying premise that an internist who becomes specialized in critical care is no longer an internist, and that both an internist and an anesthesiologist would have the same approach to critical care. The analysis almost becomes circular, concluding that the board makes no

difference because the specialities are the same, and the specialities are the same given that the board makes no difference. This point is also found in the dissent below. In a footnote, that writer questions "whether the critical care certificates are comparable in this case." A relevant inquiry would be "whether critical care certification by the ABIM and the ABA require the same or even similar training and expertise."

5. The Construction Urged by Plaintiffs Results in an Unrealistic, Unworkable and Unfair Standard.

Defining the operative specialty in terms of the medicine involved with the occurrence fails to recognize the realities of specialized medicine. As documented at length earlier herein, the various primary boards have a long history of focusing upon specialized training. Recent decades have seen marvelous changes in modern medicine, which require increasingly particularized knowledge to master. This has led to the development of certification in various sub-fields. The differing primary boards each make their own determination as to which additional certificates, if any, will be offered to their members. The standard necessary to reach either level (primary board or subspecialty) for all boards universally includes actual training and practice experience, spread over time, in narrow and specialized disciplines. Most of the board and speciality certifications also require periodic re-evaluation, requiring proof that a physician remains current with the subject matter. This focused background and training must influence the approach to patient care, and cannot realistically be ignored in determining the applicable standard of care.

Failure to recognize the significance of specialized training would result in physicians being held to an unfairly high standard. Usually, this would not present a problem, as in most cases a physician would be practicing within his or specialty. In that case, both Plaintiff's and Defendants' proposed approaches come to the same conclusion, that the specialty being practiced

(which matches the defendant's training) is the specialty which the expert witness must match. *Tate* presents a workable rule, when properly limited to this fact pattern. However, if the type of medicine involved in the operative occurrence were to always control, a physician could be held to the standard of care of a specialty in which he or she lacked training, every time the treatment being provided veered into another area of medicine. For example, a cardiologist treating chest pain could be held to the knowledge expected of a neurologist, when the underlying problem turned out to be a constricted nerve. A board certified family practice specialist who treats patients across the entire spectrum could regularly tread on thin ice. Similarly, pediatricians and emergency department specialists could be required to know just about everything. Virtually any group of physicians could find themselves held to the standard of a specialist in the area of medicine related to a particular patient complaint. While this is clearly not an intended result of the legislation, it logically must follow from the construction offered by Plaintiff.

Plaintiff's analysis leads to a standard that is not only unfair, but is also unworkable. If the standard of care is defined by the field of medicine involved at the time of the occurrence, the door has been opened to a landslide of litigation as to the specific field of medicine at issue. There are no guideposts to look to, such as the specialty in which a defendant has obtained verifiable credentials or can demonstrate an ongoing office practice. Rather, the standard of care would be determined by the type of medicine involved in the alleged negligence. Any issue which could be found by a retained specialist in any field could be used as the basis for a claim. Particularly where the claim involved the omission of a certain treatment, or the failure to contact an appropriate consultant, the plaintiff could create an issue as to the applicable standard of care, simply by arguing that a specialist in a particular field would have known, and done, something different. There would be no clear rules or defining factors to clearly identify the controlling specialty.

C. Application Herein.

The present claim, presenting apparently matching critical care certificates and differing primary boards, falls squarely on the horns of the dilemma behind determination of the appropriate specialty. The defendant is differently boarded than the expert witness, and an analytical question exists as to whether their specialties are the same (a discussion which is taken up below). By focusing upon the subspecialty as the controlling factor, the Court of Appeals below disregarded the board certification provisions of the statute, and therefore the training of the physicians involved. The defining factor herein should be the credentials of the defendant. This leads to a discussion of whether this includes both primary and specialty credentials, as discussed under Issue III.

ISSUE III. PROPER CONSTRUCTION OF THE PHRASE "THAT SPECIALTY" IN THE SECOND SENTENCE OF MCL §600.2169(1)(A) REQUIRES REFERENCE TO THE SPECIALTY IN WHICH A DEFENDANT IS BOARD CERTIFIED, MANDATING A MATCHING OF BOTH SPECIALTY AND PRIMARY BOARD CERTIFICATION.

A. Issue Presented.

The final question builds on the previous two. Assuming reference to board certification is mandatory, and the training and experience of the defendant are pertinent to the definition of the applicable standard of care, the final discussion addresses whether the board certification matching must include not only the specialty certification but the primary board as well.

The dispute is particularly applicable to the present claim, as both the defendant and the expert have a specialty certificate in critical care, issued by differing primary boards. The question herein is whether an anesthesiology certificate in critical care matches an internal medicine certificate in critical care.

B. "That Speciality" Requires Reference to the Board Certification Requirements as well as the Specialization Requirements of a Board Certified Defendant.

MCL §600.2169(1) requires that an expert match both the specialty certificate and the primary board which issued it. The language used, the legislative history and evidence of intent, and the realities of modern medicine, all dictate that the primary board be a factor in the analysis.

1. The Language Used Favors Reference to the Board as well as the Specialty.

Three wording choices in the operative sentence deserve attention. First, the opening word is "however," which tells us that the second sentence imposes an additional requirement, which must be considered in spite of whether the previous terms have been met. Since the first sentence focuses upon specialization without qualification, the sentence introduced by "however" must refer to something more than just specialization. This sentence specifically focuses in upon the board, rather than the specialty, and requires that it match as well.

The second significant wording choice is the phrase "a specialist who is board certified". This language suggests that the board certification relates to the particular specialty the defendant practices. The language mirrors the reference to the defendant's credentials, which is applied "if the party is a specialist who is board certified". The expert must match the board which certified the defendant, rather than simply possessing a primary board certification in any field. If any primary board were sufficient, the statute would more likely read "is a board certified specialist." This statute, as actually written, is more sensibly interpreted as referring to a defendant who specializes, and has obtained a specific board's certification in that speciality. The expert must have done likewise.

Finally, the sentence uses "that specialty" to define the precise credential which the expert witness must match. This format requires that "that specialty" refer to a specialty previously identified in the sentence. The only such specialty is that in which the defendant is board

certified. Nothing in the sentence suggests that the specialty should be defined by referring to the preceding sentence, nor does it provide any other reason to define the specialty in terms of the type of treatment at the time of the occurrence. As written, the statute tells us that "that specialty" must be the specialty in which the defendant "is a specialist who is board certified."

2. Evidence of Legislative Intent Favors Reference to the Board as well as the Specialty.

In reference to "that specialty," one key indicator of legislative intent is available, in addition to the general discussion of tort reform above. In the previous version of the statute, which was amended by the 1993 tort reforms, a plaintiff's expert was qualified if he or she practiced in the same or a similar specialty. One of the clearly stated purposes of the reforms was to tighten up the expert witness requirements. One method of doing so was to delete the reference to similar specialties. This adds yet another indicator that the legislation was intended to require matching of both primary and subspecialty certification. This observation seems particularly applicable to the present case, involving "similar" critical care credentials from differing primary boards.

3. The Status and Structure of Available Boards and Specialties Favors Reference to the Board as well as the Specialty.

Reference to the credentialing criteria of the various boards lends further support for the proposition that specialization requirements must take into account both the primary board and the speciality certification. Specialized training typically begins immediately upon completion of medical school, and extends over several years, as a part of the initial primary board certification process. An applicant must demonstrate satisfactory completion of a directed course of study, and then pass an examination to demonstrate adequate mastery of the subject matter. Periodic re-certification insures that boarded physicians remain current in their primary fields. This

comprehensive and ongoing educational process surely has an effect on a physician's approach to patient care.

The primary board training is a controlling factor in the ability to obtain specialty certification. Each of the boards makes its own determination as to which certificates to offer. Some have no added credentials available, others offer a specialty which can only be obtained from those boards, and yet others issue a certificate with a title matching that issued by one or more other boards. Each of these additional certifications is made available to a limited class of candidates. Possession of a medical license is not enough to get one in the door for an examination. Two other criteria must be satisfied, including completion of the certification process in a primary board, and participation in an additional specialized program as monitored and administered by that primary board. There are very few arrangements in place which allow a member of one primary board to sit for a specialty exam by another board, and then only when strict conditions are met. In this light, it is clearly evident that, at least to those who issue primary and specialty certification, the underlying board is a crucial factor.

4. The Court of Appeals Wrongly Applied *Tate* to the Specialty/Subspecialty Relationship.

As discussed above, the Court of Appeals below relied upon *Tate* for the conclusion that the controlling specialty was that involved at the time of the occurrence. The lower court therefore concluded that board certification could be ignored. It then opined that the defendant and the expert witness, by both having a certificate in critical care medicine, practiced in the same specialty. This led to the result that primary board certification could be ignored.

The appellate court erred in failing to recognize the limited applicability of *Tate*. While that decision addressed a fact pattern involving a defendant with multiple specialties, one of which was being practiced at the time of the occurrence, *Tate* was treated as creating a broad rule

that specialty should always be defined by the time of the occurrence. No emphasis was placed upon the primary board credentials. Rather, that section of the statute was explicitly disregarded. However, *Tate* is not applicable and this reliance was misplaced.

5. The Construction Urged by Plaintiffs Results in an Unrealistic, Unworkable and Unfair Standard.

The analysis herein is similar to that discussed under the same heading at Issue II. Any attempt to define the operative specialty in terms of the medicine being practiced, or the condition for which the patient was being treated, would expose a defendant physician to a standard of care as to which he or she lacked the training and experience of a specialist. Plaintiff's approach would do this by requiring that the appropriate expert witness would be one who was specialized in the field of medicine most closely related to the patient's underlying condition. This approach fails to recognize the skills and knowledge base possessed by a particular physician, and creates an unfairly high standard.

Further, focus upon the speciality involved, rather than the credentials of the defendant, would lead to increasing complexity and unnecessary litigation in regards to determination of the appropriate specialty in a given action. When the general categories of medicine are further divided into sub-specialities, the potential for confusion regarding the applicable speciality becomes even more of a threat. For example, when an emergency physician treated a child with chest pain, there would be room to debate not only whether the primary field of emergency medicine or pediatrics controlled, but also whether the appropriate specialty was actually pediatric cardiology. Any number of different specialists might be suitable experts, if the operative specialty was defined by the condition being treated. While it may be fair to allow an expert to match only one specialty a defendant possesses (the one involved at the time of the

occurrence), the specialty to be matched must be defined by the defendant, and be a specialty the defendant actually possesses.

The presence of a defendant and an expert with critical care certification, from differing boards, is a prime example of the dilemma caused by treating the occurrence as the defining factor, rather than the training of the defendant. The Court of Appeals has determined that board certification is irrelevant, solely based upon the similar specialties being practiced. It determined that the underlying board is irrelevant to the approach taken by either the defendant or the expert. However, as documented above, both the ABA and the ABIM have different prerequisites for obtaining a critical care certificate. Neither would be eligible to sit for the other's exam. An anesthesiologist may be qualified, under some circumstances, to take the pediatric boards exam in critical care. The internal medicine board allows some neurologists to sit for its critical care exam. However, under any circumstances, the primary board provides the foundation which is an essential building block for eligibility in a specialty exam. It is not, as the Court of Appeals below seems to believe, optional or "unrelated".

C. Application Herein.

The Legislature determined that board certification would be essential to the qualification of an expert witness. It did so in a manner which suggests that, in addition to matching specialization, an expert must also match the primary board. The Court of Appeals herein found that two specialists, with a similar label but with entirely different educational and practice backgrounds, were a suitable match under the statute. It did so by defining the operative specialty as critical care, because that was the type of medicine most closely related to the patient's symptoms. In the process, it completely ignored the board certification provisions. This action was not surreptitious, but rather was openly and directly stated. While the Court of Appeals may have found this approach to be sympathetic and appealing, as there is a certain logic

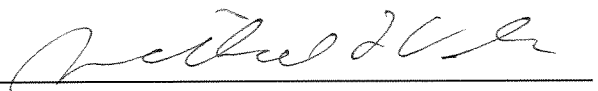
to the idea that both doctors are critical care specialists, the decision is based upon a general rule which completely misses the mark. In defining the operative specialty, the Legislature has crafted a statute which requires reference to the credentials of the defendant. When this rule is applied to the facts herein, the specialties of the Defendant and the expert witness can no longer be considered a match.

REQUEST FOR RELIEF

This Court is asked to hold that, pursuant to MCL §600.2169(1)(a), an expert witness in a malpractice action must match a defendant's credentials, in terms of primary and speciality certification. The Court is further asked to hold that the operative specialty in determining the credentials and expert witness must possess is that specialty in which the defendant is specialized and/or certified, in the process explaining and limiting the Court of Appeals decision in *Tate*.

Respectfully submitted,

JOHNSON & WYNGAARDEN, P.C.

By 

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I:\RMW\Halloran\SCt\BriefOnAppeal

EXHIBIT A

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF CALHOUN

Estate of DENNIS J. HALLORAN,
Deceased, by EILEEN HALLORAN,
Temporary Personal Representative,

Plaintiff,

vs.

RAAKESH C. BHAN, M.D.,
CRITICAL CARE PULMONARY MEDICINE,
P.C. and BATTLE CREEK HEALTH SYSTEMS,

Defendants.
_____/

File No. 98-3953-NH

Hon. James C. Kingsley

ORDER GRANTING DEFENDANTS' MOTION TO STRIKE PLAINTIFF'S EXPERT WITNESS

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At a session of said Court held in the City of Battle Creek, County of Calhoun, State of Michigan, this 21 day of DEC., 1999

PRESENT: HONORABLE JAMES C. KINGSLEY
Circuit Judge

This matter having come to be heard on Defendants' Motion to Strike Plaintiff's Expert Witness, heard before this Court on November 22, 1999, the Court having reviewed the briefs of the parties, entertained oral argument and being otherwise fully advised in the premises;

IT IS HEREBY ORDERED that Defendants' Motion to Strike Plaintiff's Expert Witness, T. James Gallagher, M.D., be and hereby is granted for the reasons stated on the record.

IT IS FURTHER ORDERED that the trial date of December 1, 1999 be and hereby is adjourned pending Plaintiff seeking an appellate remedy.

The Court further finds that the issue raised by Defendant's motion is important to the jurisprudence of the state, is one on which there is no known appellate decision, is one which is likely to arise in other cases because of the manner in which medicine is practiced today, is one on which trial courts and counsel may benefit from guidance of the appellate court and establishment of a uniform rule and is one which is important to the trial of this case.

JAMES C. KINGSLEY

Hon. James C. Kingsley
Circuit Judge

FRASER TREBILCOCK DAVIS & FOSTER, P.C. LAWYERS LANSING, MICHIGAN 48933

EXHIBIT B

STATE OF MICHIGAN

COURT OF APPEALS

EILEEN HALLORAN, Temporary Personal Representative of the ESTATE of DENNIS J. HALLORAN, Deceased,

Plaintiff-Appellant,

v

RAAKESH C. BHAN, M.D., CRITICAL CARE PULMONARY MEDICINE, P.C., and BATTLE CREEK HEALTH SYSTEMS,

Defendants-Appellees.

UNPUBLISHED
March 8, 2002

No. 224548
Calhoun Circuit Court
LC No. 98-003953-NH

Before: Fitzgerald, P.J., and Hoekstra and Markey, JJ.

PER CURIAM.

In this medical malpractice action, plaintiff appeals by leave granted the trial court's order striking plaintiff's expert witness because the expert's board certification did not match the board certification of defendant Bhan.[1] MCL 600.2169(1)(a). We reverse and remand.

At the time of the treatment giving rise to plaintiff's cause of action, defendant was board certified by the American Board of Internal Medicine (ABIM) and held a certificate of added qualification in critical care medicine, also from the ABIM. The parties agree that no separate board certification exists for critical care medicine. Rather, the different primary boards of medicine issue certificates of added qualifications in various subspecialties, including critical care medicine. In his answer to plaintiff's complaint in this matter, defendant admitted that he was practicing critical care medicine at the time he was caring for plaintiff's decedent.

Dr. Thomas Gallagher signed the required affidavit of merit that was attached to plaintiff's complaint, and plaintiff also filed an expert witness list naming Gallagher as an expert

[1] The issue presented in this appeal relates to defendant hospital Battle Creek Health Systems (BCHS) and Critical Care Pulmonary Medicine, P.C., Bhan's professional corporation, only on agency principles, and therefore the singular "defendant" will refer only to defendant Bhan.

witness who would testify regarding the standard of care applicable to defendant. In his affidavit, Gallagher testified that he "practice[d] the specialty of critical care medicine." Gallagher testified at his deposition that he is board certified in anesthesiology by the American Board of Anesthesiology and holds a certificate of special qualification from that primary board of medicine (ABA) in critical care medicine.

Defendant moved the trial court for an order striking Dr. Gallagher as an expert witness because he did not meet the statutory requirements for an expert to provide standard of care testimony for or against defendant established by MCL 600.2169(1)(a). The parties submitted briefs, and the trial court heard oral arguments. Defendant argued that because Dr. Gallagher was not certified by the American Board of Internal Medicine, as defendant was, Gallagher did not meet the criteria of the statute (emphasizing the certification by the primary board of medicine). Plaintiff countered that where the area of actual medicine practiced and at issue (here the subspecialty of critical care) lacked its own board granting certification, the focus should be on the actual subspecialty being practiced and out of which the alleged malpractice stems. Furthermore, plaintiff asserted that because both defendant and Gallagher held certificates of added qualifications (albeit from different primary boards of medicine), and both practiced critical care medicine as a specialty (that does not offer board certification), under the circumstances of this case, Dr. Gallagher was qualified to serve as an expert witness.

The trial court construed MCL 600.2169(1)(a) consistent with defendant's position, finding that the Legislature intended to refer to primary board certifications and because Gallagher was not board certified in the same primary specialty as defendant, he was not qualified to render standard of care testimony for or against defendant. The trial court therefore granted defendant's motion to strike.

MCL 600.2169(1)(a) provides in pertinent part:

> (1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> > (a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.

Plaintiff asserts that the first sentence of subparagraph (a) of subsection (1) provides that if the defendant is a specialist at the time of the occurrence, then the expert witness must specialize in that same specialty that serves as the basis for the action. Plaintiff further argues that the last sentence of subparagraph (a) of subsection (1) does not apply to this case because the subspecialty at issue, critical care medicine, does not have a primary board of medicine offering certification. We agree. Whether a witness is qualified to serve as an expert witness and the

actual admissibility of the expert's testimony are within the trial court's discretion. *Tate v Detroit Receiving Hosp*, ___ Mich App ___ ; ___ NW2d ___ (Docket No. 225833, issued January 15, 2002), slip op at 2. We review the trial court's decision for an abuse of discretion. *Id.*

The primary goal in construing a statute is to determine and give effect to the intent of the Legislature. *Frankenmuth Mutual Ins Co v Marlette Homes, Inc*, 456 Mich 511, 515; 573 NW2d 611 (1998). The specific language of the statute is the first source for determining the Legislature's intent, *In re MCI Telecommunications Complaint*, 460 Mich 396, 411; 596 NW2d 164 (1999), and when the plain and ordinary meaning of the language is clear, judicial construction is normally not needed or permitted, *Sun Valley Foods Co v Ward*, 460 Mich 230, 236; 596 NW2d 119 (1999). Courts can look beyond the statutory language only if it is ambiguous. *Nawrocki v Macomb Co Rd Comm'n*, 463 Mich 143, 159; 615 NW2d 702 (2000). In such cases, courts must seek to give effect to the Legislature's intent through a reasonable construction. *Macomb Co Prosecutor v Murphy*, 464 Mich 149, 158; 627 NW2d 247 (2001); *Tate, supra*, slip op at 4.

In deciding this case, we rely on this Court's analysis and holding in the recent opinion of *Tate, supra.* In the medical malpractice action in *Tate, supra,* slip op at 1-2, the plaintiff proffered an expert witness who was board certified and a specialist in internal medicine to testify against the defendant hospital's physician who was board certified in several specialties, including internal medicine. The plaintiff's theory in *Tate* was that the medical malpractice occurred during the practice of internal medicine and not during the practice of the other specialties. *Id.* at 5. The trial court concluded, however, that because the expert witness was not board certified in the exact same specialties as the defendant's physician, the expert witness was unqualified to testify. *Id.* at 2. This Court examined MCL 600.6129(1)(a), the statute at issue in the present case, and reversed the trial court. This Court stated:

> [MCL 600.]2169(1)(a) specifically states that an expert witness must "specialize[] at the time of the occurrence that is the basis for the action" in the same specialty as the defendant physician. The statute further discusses board certified specialists and requires that experts testifying against or on behalf of such specialists also be "board certified in that specialty." The use of the phrase "at the time of the occurrence that is the basis for the action" clearly indicates that an expert's specialty is limited to the actual malpractice. Moreover, the statute expressly uses the word "specialty," as opposed to "specialties," thereby implying that the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant physician may hold. Indeed, *McDougall [v Schanz,* 461 Mich 15, 24-25; 597 NW2d 148 (1999)], states that "the statute operates to preclude certain witnesses from testifying solely on the basis of the witness' lack of practice or teaching experience in the *relevant* specialty."
>
> * * *
>
> Certainly § 2169 cannot be read or interpreted to require an exact match of every board certification held by a defendant physician. Such a "perfect match"

> requirement would be an onerous task and in many cases make it virtually impossible to bring a medical malpractice case. . . . [W]e do not believe that *McDougall* stands for such a proposition. . . . Thus, where a defendant physician has several board certifications and the alleged malpractice only involves one of these specialties, § 2169 requires an expert witness to possess the same specialty as that engaged in by the defendant physician during the course of the alleged malpractice. [*Tate, supra*, slip op at 4-5; emphasis in original.]

Similarly, the alleged malpractice in the instant case that serves as the basis for the action involves critical care medicine and not other specialties in which Gallagher and defendant are certified. There is no dispute that both defendant and Gallagher specialize in critical care medicine and are certified in critical care medicine. The fact that Dr. Gallagher lacks a board certification in internal medicine is irrelevant because plaintiff has not alleged malpractice against defendant for treatment rendered by defendant acting as an internist. As stated in *Tate, supra*, slip op at 4, "specialty" as it is used in MCL 600.2169(1)(a) is tied to the occurrence of the alleged malpractice and not the unrelated specialties that the physician may possess. Thus, contrary to defendant's assertion, the second sentence of § 2169(1)(a), which states that "if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified *in that specialty,*" refers to the critical care specialty that serves as the basis for the action and not the specialty of internal medicine. Because there is no board certification for critical care medicine, the last sentence of § 2169(1)(a) does not apply to the present case. Therefore, Dr. Gallagher's and defendant's qualifications were matched for purposes of the statute.

We reverse and remand for further proceedings. We do not retain jurisdiction.

/s/ E. Thomas Fitzgerald
/s/ Jane E. Markey

STATE OF MICHIGAN

COURT OF APPEALS

EILEEN HALLORAN, Temporary Personal Representative of the ESTATE of DENNIS J. HALLORAN, Deceased,

Plaintiff-Appellant,

v

RAAKESH C. BHAN, M.D., CRITICAL CARE PULMONARY MEDICINE, P.C., and BATTLE CREEK HEALTH SYSTEMS,

Defendant-Appellees.

UNPUBLISHED
March 8, 2002

No. 224548
Calhoun Circuit Court
LC No. 98-003953-NH

Before: Fitzgerald, P.J., and Hoekstra and Markey, JJ.

HOEKSTRA, J. *(dissenting).*

I respectfully dissent.

In this case, it is undisputed that defendant Bahn was board certified by the American Board of Internal Medicine (ABIM) and held a certificate of added qualification in critical care medicine from the ABIM and that plaintiff offered as her expert witness Dr. Thomas Gallagher, who is board certified by the American Board of Anesthesiology (ABA) and holds a certificate of special qualification in critical care medicine from the ABA.

On these facts, I respectfully disagree with the conclusion of the majority that the second sentence of MCL 600.2169(1)(a) does not apply in this case. Defendant Bahn's board certification plainly invoked the board certification provision of section 2169(1)(a) relative to physicians who testify either on his behalf or against him. Unlike the majority, I view the board certification itself, not the certificate of added or special qualification, to be the defining credential for purposes of analyzing the applicability of the second sentence of section 2169(1)(a)[1].

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[1] Although not dispositive, in my opinion, I also question whether the critical care certifications are comparable in this case. I find no evidence in the record upon which to conclude whether critical care certification by the ABIM and the ABA require the same or even similar training and expertise.

I also believe that the majority's reliance upon *Tate v Detroit Receiving Hosp,* ___ Mich App ___; ___ NW2d ___ (Docket No. 225833, issued 1/15/2002) is misplaced. *Tate* is distinguishable because, ultimately, the operative board certifications of the two doctors at issue in *Tate* were the same. Here, they are different.

/s/ Joel P. Hoekstra

EXHIBIT C

ABMS Member Boards: APPROVED CERTIFICATES
GENERAL CERTIFICATES

Table 1

American Board of	Incorp. Year	Approved as Member Board	Certificates	First Issued (1)	TimeLimited Certificates: First Issued (1) Month/Year	TimeLimited Certificates: Duration Years
Allergy & Immunology (4)	1971	1971	Allergy & Immunology	1972	10/89	10
Anesthesiology	1938	1941	Anesthesiology	1938	1/00	10
Colon & Rectal Surgery	1935	1949	Colon & Rectal Surgery (4)	1940	1/91	10
Dermatology (2)	1932	1933	Dermatology	1932	11/91	10
Emergency Medicine	1976	1979	Emergency Medicine	1980	6/80	10
Family Practice	1969	1969	Family Practice	1970	3/70	7
Internal Medicine (4)	1936	1936	Internal Medicine	1937	8/90	10
Medical Genetics (3,4)	1980	1991	Clin Biochem Genetics	1982	9/93	10
			Clin Cytogenetics	1982	9/93	10
			Clin Genetics - M.D.	1982	9/93	10
			Clin Molecular Genetics	1993	9/93	10
			Ph.D. Medical Genetics	1982	9/93	10
Neurological Surgery (7)	1940	1940	Neurological Surgery	1940	5/99	10
Nuclear Medicine	1971	1971	Nuclear Medicine	1972	1/92	10
Obstetrics & Gynecology (2)	1930	1933	Obstetrics & Gynecology	1930	1/86	10
Ophthalmology (2)	1917	1933	Ophthalmology	1916	7/92	10
Orthopaedic Surgery	1934	1935	Orthopaedic Surgery	1935	7/86	10
Otolaryngology (2)	1924	1933	Otolaryngology	1925	††	10

ABMS Member Boards: APPROVED CERTIFICATES
GENERAL CERTIFICATES

Table 1
(continued)

American Board of	Incorp. Year	Approved as Member Board	Certificates	First Issued (1)	TimeLimited Certificates: First Issued (1) Month/Year	TimeLimited Certificates: Duration Years
Pathology	1936	1936	Anatomic Pathology & Clinical Pathology	1936	—	
			Anatomic Pathology	1936	—	
			Clinical Pathology	1936	—	
Pediatrics	1933	1934	Pediatrics	1934	5/88	7
Physical Medicine & Rehabilitation	1947	1947	Physical Medicine & Rehabilitation	1947	5/93	10
Plastic Surgery	1937	1941	Plastic Surgery	1939	11/95	10
Preventive Medicine (4)	1948	1949	Aerospace Medicine	1953	1/98	10
			Occupational Medicine	1955	1/98	10
			Public Health & General Preventive Medicine(5)	1983	1/98	10
Psychiatry & Neurology		1935	Psychiatry	1935	11/94	10
			Neurology	1935	11/94	10
			Neurology with Special Qualifications in Child Neurology	1968	11/94	10
Radiology (4, 6)	1934	1935	Diagnostic Radiology	1965	††	10
			Radiation Oncology(5)19	87	6/95	10
			Radiological Physics	1947	††	10
Surgery	1937	1937	Surgery	1937	1/76	10
Thoracic Surgery	1950	1970	Thoracic Surgery	1948	1/76	10
Urology	1935	1935	Urology	1935	2/85	10

EXHIBIT D

ABMS Member Boards: APPROVED CERTIFICATES
SUBSPECIALTY CERTIFICATES

Table 1

American Board of	Subspecialty	Date Approved by ABMS	First Issued (1)	TimeLimited First Issued (1) Month/Year	Certificates Duration Years
Allergy & Immunology	Clinical Laboratory Immunology(5)	1983	1986	10/94	10
Anesthesiology	Critical Care	1985	1986	1/00	10
	Pain Management	1991	1993	10/93	10
Colon & Rectal Surgery	No subspecialties				
Dermatology	Clinical & Laboratory Dermatological Immunology(5)	1983	1985	—	
	Dermatopathology	1973	1974	—	
	Pediatric Dermatology	2000	††	††	
Emergency Medicine	Medical Toxicology	1992	1995	1/95	10
	Pediatric Emergency Medicine	1991	1993	2/93	10
	Sports Medicine	1991	1993	12/93	10
	Undersea and Hyperbaric Medicine	2000	††	††	10
Family Practice	Adolescent Medicine	2000	††	††	
	Geriatric Medicine	1985	1988	4/88	10
	Sports Medicine	1989	1993	9/93	10
Internal Medicine (4)	[Allergy & Immunology](4)				
	Adolescent Medicine	1992	1994	11/94	10
	Cardiovascular Disease	†	1937	11/91	10
	Clinical Cardiac Electrophysiology(5)	1989	1992	11/92	10
	Clinical & Laboratory Immunology(5)	1983	1986	10/90	10
	Critical Care Medicine	1985	1987	11/87	10
	Endocrinology, Diabetes and Metabolism(5)	1971	1972	11/91	10
	Gastroenterology	†	1936	11/91	10
	Geriatric Medicine	1985	1988	4/88	10
	Hematology	1971	1972	11/90	10
	Infectious Disease	1971	1972	11/90	10
	Interventional Cardiology	1996	1999	11/99	10
	Medical Oncology	1972	1973	11/91	10
	Nephrology	1971	1972	11/90	10
	Pulmonary Disease	†	1937	11/90	10
	Rheumatology	1971	1972	11/90	10
	Sports Medicine	1992	1993	9/93	10
Medical Genetics	Molecular Genetic Pathology	1999	2001	11/01	10
Neurological Surgery (7)	No Subspecialties				
Nuclear Medicine	No Subspecialties				
Obstetrics & Gynecology	Critical Care Medicine	1985	1991	12/91	6
	Gynecologic Oncology	1972	1974	12/87	6
	Maternal & Fetal Medicine	1973	1974	12/87	6
	Reproductive Endocrinology	1973	1974	12/87	6
Ophthalmology	No Subspecialties				
Orthopaedic Surgery	Hand Surgery	1986	1989	2/89	10
Otolaryngology	Otology/Neurotology	1992	††	††	10
	Pediatric Otolaryngology	1992	††	††	10
	Plastic Surgery within the Head and Neck	1998	††	††	10

ABMS Member Boards: APPROVED CERTIFICATES
SUBSPECIALTY CERTIFICATES

Table 1
(continued)

American Board of	Subspecialty	Date Approved by ABMS	First Issued (1)	Time Limited First Issued (1) Month/Year	Certificates Duration Years
Pathology	Blood Banking/ Transfusion Medicine(5)	1972	1973	—	
	Chemical Pathology	†	1951	—	
	Cytopathology	1988	1989	—	
	Dermatopathology	1973	1974	—	
	Forensic Pathology	†	1959	—	
	Hematology	†	1955	—	
	Immunopathology (7)	1983	1983	—	
	Medical Microbiology	†	1950	—	
	Molecular Genetic Pathology	1999	††	—	
	Neuropathology	†	1948	—	
	Pediatric Pathology	1989	1990	—	
Pediatrics	Allergy & Immunology(4)				
	Adolescent Medicine	1991	1994	11/94	7
	Clinical & Laboratory Immunology(5)	1983	1986	10/96	10
	Developmental-Behavioral Pediatrics	1999	††	††	7
	Medical Toxicology	1992	1994	11/94	10
	Neonatal-Perinatal Medicine	1974	1975	11/89	7
	Neurodevelopmental Disabilities	1999	††	††	10
	Pediatric Cardiology	†	1961	10/88	7
	Pediatric Critical Care Medicine	1985	1987	7/87	7
	Pediatric Emergency Medicine	1991	1992	11/92	7
	Pediatric Endocrinology	1976	1978	7/89	7
	Pediatric Gastroenterology	1988	1990	11/90	7
	Pediatric Hematology-Oncology	1973	1974	7/90	7
	Pediatric Infectious Diseases	1991	1994	11/94	7
	Pediatric Nephrology	1973	1974	7/88	7
	Pediatric Pulmonology	1984	1986	7/86	7
	Pediatric Rheumatology	1990	1992	5/92	7
	Sports Medicine	1990	1993	9/93	10
Physical Medicine & Rehabilitation	Spinal Cord Injury Medicine	1995	1998	12/98	10
	Pain Management	1998	2000	9/00	10
	Pediatric Rehabilitation Medicine	1999	††	††	
Plastic Surgery	Hand Surgery	1986	1989	1/89	10
	Plastic Surgery Within the Head and Neck	2000	††	††	10
Preventive Medicine	Medical Toxicology	1992	1995	1/85	10
	Undersea & Hyperbaric Medicine	1989	1993	1/93	10
Psychiatry & Neurology	Addiction Psychiatry	1991	1993	3/93	10
	Child & Adolescent Psychiatry(5)	†	1959	9/95	10
	Clinical Neurophysiology	1990	1992	3/92	10
	Forensic Psychiatry	1992	1994	10/94	10
	Geriatric Psychiatry	1989	1991	4/91	10
	Neurodevelopmental Disabilities	1999	2000	4/00	10
	Pain Management	1998	2000	4/01	10
Radiology	Neuroradiology	1994	1995	2/95	10
	Nuclear Radiology	1972	1974	††	10
	Pediatric Radiology	1993	1994	11/94	10
	Vascular & Interventional Radiology	1994	1994	11/94	10
Surgery	Vascular Surgery(4)	1982	1982	6/82	10
	Pediatric Surgery	1973	1974	6/74	10
	Surgery of the Hand	1986	1989	1/89	10
	Surgical Critical Care	1985	1986	6/86	10
Thoracic Surgery	No Subspecialties				
Urology	No Subspecialties				

FOOTNOTES TO TABLE 1

† Certificates issued prior to 1972 when ABMS recognition procedures were established.
†† Certificates not issued.
1. First year general certificate issued.
2. Founding member of ABMS.
3. American Board of Medical Genetics (ABMG) certificates established prior to becoming an ABMS Member Board.
4. Certificates only issued during years indicated.

American Board of	Certificate Name	Dates Issued
Colon & Rectal Surgery	Anorectal Surgery	1949-54
	Proctology	1940-56
Internal Medicine	Allergy & Immunology	1936-71
Medical Genetics	Clinical Biochemical/Molecular Genetics	1990-93
Pathology	Radioisotopic Pathology (7)	1974-90
	Immunopathology (7)	1983-99
Pediatrics	Allergy & Immunology	1944-71
Preventive Medicine	General Preventive Medicine	1960-82
	Public Health	1949-82
Radiology	Diagnostic Radiology with Special Competence in Nuclear Radiology	1979-90
	Diagnostic & Medical Nuclear Physics	1976-98
	Diagnostic Roentgenology	1934-68
	Nuclear Medicine	1957-66
	Radiological Physics	1947-98
	Radiology	1934-96
	Radium Therapy	1939-60
	Roentgenology	1934-64
	Roentgen Ray & Gamma Ray Physics	1961-75
	Therapeutic & Diag. Radiological Physics	1973-98
	Therapeutic & Medical Nuclear Physics	1976-98
	Therapeutic Roentgenology	1935-53
	X-Ray and Radium Physics	1947-66
Surgery	Vascular Surgery - as a Certificate of Special Qualifications	1982-89

5. Certificate names have changed and were issued during the years indicated:

American Board of	Current Certificate Name	Previous Certificate Name	Dates Issued
Allergy & Immunology	Clinical & Laboratory Immunology	Diagnostic Laboratory Immunology	1986-90
Dermatology	Clinical & Laboratory Dermatological Immunology	Dermatological Immunology/ Diagnostic & Laboratory Immunology	1985-91
Internal Medicine	Clinical Cardiac Electrophysiology	Cardiac Electrophysiology	1989-91
	Clinical & Laboratory Immunology	Diagnostic Laboratory Immunology	1986-90
	Endocrinology, Diabetes & Metabolism	Endocrinology & Metabolism	1972-92
Pathology	Blood Banking/Transfusion Medicine	Blood Banking	1983-88
Pediatrics	Clinical & Laboratory Immunology	Diagnostic Laboratory Immunology	1986-90
Preventive Medicine	Public Health & General Preventive Medicine	General Preventive Medicine	1960-82
		Public Health	1949-82
Psychiatry & Neurology	Child & Adolescent Psychiatry	Child Psychiatry	1959-87
Radiology	Radiation Oncology	Therapeutic Radiology	1934-86

6. The American Board of Radiology continues to issue the following certificates in the area of Radiological Physics:

Current Certificate Name	Date First Issued
Diagnostic Radiological Physics	1974
Medical Nuclear Physics	1949
Therapeutic Radiological Physics	1973

7. Certificate inactivated:

American Board of	Certificate Name	Year Approved	Year Inactivated
Neurological Surgery	Critical Care Medicine	1985	1994
Pathology	Radioisotopic Pathology	1974	1992
	Immunopathology	1983	1999

EXHIBIT E

EDITORIAL BOARD

CRITICAL CARE MEDICINE

EDITORIAL OFFICE

Managing Editor: Kathleen F. Hoinacki, BA
Editorial Coordinator: Sandra K. Maitlen; *Editorial Assistant:* Carlyn Clayton
Director of Editorial Affairs: René M. Archè

Editorial Board Members

EXHIBIT F

ABMS Member Boards: Requirements for General Certification

Table 3

American Board of	Training and Experience — ACGME Approved (1)			Time Limits for Certification		Training Credit Accepted		Other Requirements			
	Initial Speciality Training	Advanced Specialty Training	Clinical Experience Requirement	Maximum Years to apply After Training (3)	Maximum Years to Complete Certification After Application(3)	Non-ACGME(1,3) Accredited Training	RCPSC(2,3) Years	Full License Required	Written Exam	Oral Exam	Fees for Certification Examination
Allergy & Immunology	3	2	—	No Limit	No Limit	NO	YES	YES	YES	NO	$2,000
Anesthesiology	1	3	—	12	7	NO	YES	YES	YES	YES	1,700
Colon/Rectal Surgery	5	1	—	5	7	NO	NO	YES	YES	YES	1,200
Dermatology	1	3	—	No Limit	3 Renewable	NO	YES	YES	YES	NO	1,600
Emergency Medicine	—	3	—	No Limit	No Limit	NO	YES	YES	YES	YES	1,830
Family Practice	—	3	—	No Limit	No Limit	YES	YES	YES	YES	NO	760
Internal Medicine	—	3	—	No Limit	No Limit	NO	YES	YES	YES	NO	825
Medical Genetics	2	2	—	No Limit	6	YES	NO	YES	YES	NO	1,450
Neurological Surgery	1	5	1	5	5	YES	YES	YES	YES	YES	2,435
Nuclear Medicine	1	2	—	No Limit	No Limit	NO	YES	YES	YES	NO	1,800
Obstetrics/Gynecology	—	4	2	No Limit	6	NO	YES	YES	YES	YES	2,450
Ophthalmology	1	3	—	5	6	NO	YES	YES	YES	YES	2,500
Orthopaedic Surgery	—	5	2	No Limit	5	NO	YES	YES	YES	YES	2,240
Otolaryngology	1	4	—	No Limit	1-3 yrs	NO	NO	YES	YES	YES	2,250
Pathology	3 or 4	1 or 2	1	5	5	YES	YES	YES	YES	NO	1,000/1,400
Pediatrics	—	3	—	No Limit	No Limit	YES	YES	YES	YES	NO	1,190
Physical Med & Rehab	1	3	1	No Limit	No Limit	YES	YES	YES	YES	YES	2,000
Plastic Surgery	3	2	0	2	No Limit	NO	YES	YES	YES	YES	1,500/1,500
Preventive Medicine	1	2	—	No Limit	3 Renewable	NO	YES	YES	YES	NO	1,650/1,900
Psychiatry/Neurology	—	4	—	No Limit	No Limit	NO	YES	YES	YES	YES	2,050
Radiology	—	4	1	No Limit	No Limit	YES	YES	YES	YES	YES	1,800
Surgery	—	5	—	3	5 & 5	YES	YES	YES	YES	YES	1,350
Thoracic Surgery	5	2	—	5	8	NO	NO	YES	YES	YES	2,610
Urology	1-2	3 or 4	1½	5	5	NO	NO	YES	YES	YES	1,740/1,840

1. Accreditation Council for Graduate Medical Education.
2. Royal College of Physicians and Surgeons of Canada.
3. Contact Member Board for application deadlines and specifics.

TO CONFIRM CURRENT OFFICIAL POLICY OF INDIVIDUAL SPECIALTY BOARDS, CONTACT THE RESPECTIVE BOARD.

EXHIBIT G

ABMS Member Boards: Recertification and Time-Limited Certification

Table 6

	Requirements for Recertification						Time-Limited Certificates	
American Board of	Written Exam	Oral Exam	Other Assessment Formats	License Required	CME Required	Application Fees	Year of Implementation	Duration (Years)
Allergy & Immunology	Yes	No	No	Yes	No	2,000	1989	10
Anesthesiology	Yes	No	No	Yes	No	700	2000	10
Colon/Rectal Surgery	Yes	No	No	Yes	Yes	950	1990	10
Dermatology	Yes	No	No	Yes	Yes	750	1991	10
Emergency Medicine	Yes (1)	No(3)	No	Yes	No	1,390	1980	10
Family Practice	Yes	No	Yes	Yes	Yes	760	1970	7
Internal Medicine	Yes	No	Yes	Yes	No	825	1990	10
Medical Genetics	Plan in Progress						2000	10
Neurological Surgery	Yes	No	Yes	Yes	Yes	Not Established	1999	10
Nuclear Medicine	Yes	No	No	Yes	Yes	1,000	1992	10
Obstetrics/Gynecology	Yes	No	Yes(1)	Yes	No	180-1,450(1)	1986	6
Ophthalmology	Yes	Yes	Yes	Yes	Yes	1000	1992	10
Orthopaedic Surgery	Yes(1)	Yes(1)	Yes(1)	Yes	Yes	1,500-1,700(1)	1986	10
Otolaryngology	Plan in Progress						2002	10
Pathology	Yes	No	Yes	Yes	Yes	750	1997 (2)	10
Pediatrics	Yes	No	Yes	Yes	No	545-1,090(1)	May-88	7
Phys. Med. & Rehab.	Yes	No	No	Yes	Yes	500	1993	10
Plastic Surgery	Plan in Progress	No	Yes	Yes	Yes	Not Established	1995	10
Preventive Medicine	Yes	No	Yes	Yes	Yes	Not Established	1997	10
Psychiatry & Neurology								
Psychiatry	Yes	No	No	Yes	No	1,125	1994	10
Neurology	Yes	No	No	Yes	No	1,125	1994	10
Radiology								
Diagnostic Radiology	Plan in Progress						2002	10
Radiation Oncology	Yes	No	No	Yes		1,200	1995	10
Radiologic Physics	Plan in Progress						2002	10
Surgery	Yes	No	No	Yes	Yes	675	1976	10
Thoracic Surgery	Yes	No	Yes	Yes	Yes	1,075	1976	10
Urology	Yes	No	No	Yes	Yes	1,050	1985	10

(1) Options available.

(2) Initial certificates are not time-limited. Recertification are time-limited.

(3) Only one exam is required for recertification. Candidates may choose either the written or the oral exam.

TO CONFIRM CURRENT OFFICIAL POLICY OF INDIVIDUAL SPECIALTY BOARDS, CONTACT THE RESPECTIVE BOARD.

EXHIBIT H

The American Board of Anesthesiology®

SEE ALSO

What is Anesthesiology

ABA Directors and Officers

The ABA and Certification

Frequently Asked Questions

EXAMINATION

Current Events/Information

July Written Examination

Oral Examination

Subspecialty Examinations

Recertification Examinations

APPLICATION & OTHER FORMS

Change of Address

An ABA diplomate is a physician who provides medical management and consultation during the perioperative period, in Pain Medicine and in critical care medicine.

A diplomate of the Board possesses knowledge, judgment, adaptability, clinical skills, technical facility and personal characteristics sufficient to carry out the entire scope of anesthesiology practice.

An ABA diplomate logically organizes and effectively presents rational diagnoses and appropriate treatment protocols to peers, patients, their families and others involved in the medical community.

A diplomate of the Board can serve as an expert in matters related to anesthesiology, deliberate with others and provide advice and defend opinions in all aspects of the specialty of anesthesiology.

A Board certified anesthesiologist is able to function as the leader of the anesthesiology care team.

Because of the nature of the role of the anesthesiologist, the ABA diplomate must be able to deal with emergent life-threatening situations in an independent and timely fashion.

The ability to acquire and process information in an independent and timely manner is central to assure individual responsibility for all aspects of anesthesiology care.

Adequate physical and sensory faculties, such as eyesight, hearing, speech and coordinated function of the extremities, are essential to the independent performance of the functions of the Board certified anesthesiologist.

Freedom from the influence of or dependency on chemical substances that impair cognitive, physical, sensory or motor function also is an essential characteristic of the Board certified anesthesiologist.

BACK <

EXHIBIT I

PRIMARY CERTIFICATION IN ANESTHESIOLOGY

2.01 CERTIFICATION REQUIREMENTS

At the time of certification by the American Board of Anesthesiology, the candidate shall be capable of performing independently the entire scope of anesthesiology practice (see Sections 1.02.A and 1.02.D) and must:

A. Hold a permanent, unconditional, unrestricted and unexpired license to practice medicine or osteopathy in one state or jurisdiction of the United States or province of Canada.

B. Have fulfilled all the requirements of the Continuum of Education in Anesthesiology.

C. Have on file with the American Board of Anesthesiology a Certificate of Clinical Competence with an overall satisfactory rating covering the final six-month period of Clinical Anesthesia training in each anesthesiology residency program.

D. Have satisfied all examination requirements of the Board.

E. Have a moral, ethical and professional standing satisfactory to the ABA.

ABA certificates in anesthesiology issued on or after January 1, 2000 are valid for ten years after the year the candidate passes the examination for certification. It is left to the holder of the certificate when to apply to the ABA for examination and recertification in anesthesiology.

A person certified by the ABA is designated a diplomate in publications of the American Board of Medical Specialties and the American Society of Anesthesiologists.

2.02 THE CONTINUUM OF EDUCATION IN ANESTHESIOLOGY

The continuum of education in anesthesiology consists of four years of training subsequent to the date that the medical or osteopathic degree has been conferred. The continuum consists of a Clinical Base Year (CBY) and 36 months of approved training in anesthesia (CA-1, CA-2 and CA-3 years).

A. Acceptable **CLINICAL BASE** experiences include training in internal or emergency medicine, pediatrics, surgery or any of the surgical specialties, obstetrics and gynecology, neurology, family practice, critical care medicine or any combination of these as approved for the individual resident by the director of his or her training program in anesthesiology. The

Clinical Base year must include at least ten months of clinical rotations during which the resident has responsibility for the diagnosis and treatment of patients with a variety of medical and surgical problems, of which at most one month may involve the administration of anesthesia. At most two months of the Clinical Base year may involve training in specialties that do not meet the aforementioned criteria.

During the Clinical Base year the physician must be enrolled and training as a resident in a transitional year or specialty training program in the United States or its territories that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or approved by the American Osteopathic Association, or outside the United States and its territories in institutions affiliated with medical schools approved by the Liaison Committee on Medical Education.

The resident must complete the Clinical Base year before beginning CA-3 year clinical rotations.

B. The three-year **CLINICAL ANESTHESIA** curriculum (CA 1-3) consists of experience in basic anesthesia training, subspecialty anesthesia training and advanced anesthesia training. It is a graded curriculum of increasing difficulty and learning that is progressively more challenging of the resident's intellect and technical skills.

(1) Experience in **BASIC ANESTHESIA TRAINING** is intended to emphasize basic and fundamental aspects of the management of anesthesia. It is recommended that at least 12 months of the CA-1 and CA-2 years be spent in basic anesthesia training with a majority of this time occurring during the CA-1 year.

(2) **SUBSPECIALTY ANESTHESIA TRAINING** is required to emphasize the theoretical background, subject material and practice of subdisciplines of anesthesiology. These subdisciplines include obstetric anesthesia, pediatric anesthesia, cardiothoracic anesthesia, neuroanesthesia, anesthesia for outpatient surgery, recovery room care, regional anesthesia and pain management. It is recommended that these experiences be subspecialty rotations and occupy 7-12 months of the CA-1 and CA-2 years. The sequencing of these rotations in the CA-1 and CA-2 years is left to the discretion of the program director.

In addition to the above requirements for subspecialty experiences, two months of training in **critical care medicine** are required during Clinical Anesthesia training. An acceptable critical care rotation should include active participation in patient care, active involvement by anesthesia faculty experienced in the practice and teaching of critical care, and an appropri-

ate population of critically ill patients. Experience in short-term overnight post-anesthesia units, intermediate step-down units, or emergency rooms does *not* fulfill this requirement.

(3) Experience in **ADVANCED ANESTHESIA TRAINING** constitutes the CA-3 year. The CA-3 year is a distinctly different experience than the CA 1-2 years, requiring progressively more complex training experiences and increased independence and responsibility for the resident. *Residents must complete the Clinical Base and CA 1-2 years of training before they begin clinical rotations in fulfillment of the CA-3 year requirement.*

The program director, in collaboration with the resident, will design the resident's CA-3 year of training. They will select one of two tracks designated as the advanced clinical track and the clinical scientist track. Regardless of the track selected, resident assignments in the CA-3 year should include the more difficult or complex anesthetic procedures and care of the most seriously ill patients.

Residents in the **ADVANCED CLINICAL TRACK** are required to complete a minimum of six months of advanced anesthesia training. They may spend the remaining six months in advanced anesthesia training or in one to three selected subspecialty rotations. Residents may train in one anesthesia subspecialty for at most six months during the CA-3 year and no more than twelve months during the CA 1-3 years.

The **CLINICAL SCIENTIST TRACK** consists of clinical training in combination with research experience. Research may occur at any time during residency training although often it will be conducted in the CA-3 year. *The resident must be enrolled in an ACGME-accredited anesthesiology program and remain active in the educational component of the program while pursuing research.* There are two options for fulfilling the requirements of this track.

Option A of the Clinical Scientist Track may be fulfilled by completing six months of clinical or laboratory research experience during 48 months of training which must include 12 months of Clinical Base and a minimum of 30 months of Clinical Anesthesia.

Option B of the Clinical Scientist Track, intended for residents who plan careers as **academic investigators,** may be fulfilled by completing 18 months of clinical or laboratory research at any time during 60 months of training which must include 12 months of Clinical Base and a minimum of 30 months of Clinical

Anesthesia. They are eligible for entrance into the ABA examination system after they have completed their Clinical Base requirement, 30 months of Clinical Anesthesia satisfactorily, and a minimum of six months of research experience.

Regardless of which Clinical Scientist option is chosen, a resident who elects this track must have a satisfactory Clinical Competence Committee report for the 6 months of Clinical Anesthesia training immediately preceding any research period.

The anesthesiology program director may request six months of credit toward the research component of Option B for a resident with a Ph.D. degree in a discipline relevant to Anesthesiology. Documents supporting this request should include documentation of the Ph.D. degree, a description of the current research, and a copy of the resident's curriculum vitae. Approval is at the discretion of the Credentials Committee and must be obtained prior to the start of the last 12 months of residency training. Credit will be granted only upon *completion* of all other requirements of Option B of the clinical scientist track.

C. The ABA grants credit toward the CA 1-3 year requirements for Clinical Anesthesia training that satisfies *all four* of the following conditions:

(1) The CA 1-3 years of training are spent as a resident enrolled with the ABA by no more than two ACGME-accredited anesthesiology residency programs in the United States or its territories.

(2) The period of Clinical Anesthesia training as an enrolled resident of any single program is at least six months of uninterrupted training.

(3) The six-month period of Clinical Anesthesia training in any one program ends with receipt of a satisfactory Certificate of Clinical Competence. *To receive credit from the ABA for a period of Clinical Anesthesia training that occurs on or after July 1, 2000, and is not satisfactory, the resident must immediately complete an additional six months of uninterrupted Clinical Anesthesia training in the same program with receipt of a satisfactory Certificate of Clinical Competence.* If a resident receives consecutive Certificates of Clinical Competence that are not satisfactory, additional training is required. When a resident receives a satisfactory Certificate of Clinical Competence immediately following consecutive periods of training that are not satisfactory, the ABA will grant credit only for the period of satisfactory training and the period of unsatisfactory training immediately preceding it.

(4) No more than six months during the first two Clinical Anesthesia years, and a maximum of 12 months during the three years of Clinical Anesthesia training, are spent training outside the parent programs in affiliated or non-affiliated institutions. **The Credentials Committee of the ABA must prospectively approve Clinical Anesthesia training in non-affiliated programs** (see Section 2.02.D). The prospective request for approval must include a chronological description of the rotations, information about the supervision of the resident, and assurances that the resident will be in compliance with the limits on training outside the parent program. Further, the resident must remain enrolled in the parent program while training at an affiliated or non-affiliated institution, and the parent program must report the training on the Clinical Competence Committee report filed for the period involved.

D. Prospective approval is required for exceptions to policies regarding the training planned for residents (see Sections 2.02.B(3) and 2.02.C(4) above). The Credentials Committee of the ABA considers requests for prospective approval on an individual basis. The ABA office must receive the request from the department chair on behalf of a resident at least ***two months*** before the resident begins the training in question. It is the responsibility of the department chair and the resident to assure that the request is received in a timely manner.

2.03 ABSENCE FROM TRAINING

The total of any and all absences during Clinical Anesthesia training may not exceed the equivalent of 20 working days per year. Attendance at scientific meetings, not to exceed five working days per year, shall be considered a part of the training program. Duration of absence during the Clinical Base year may conform to the policy of the institution and department in which that portion of the training is served. Absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence.

A lengthy interruption in training may have a deleterious effect upon the resident's knowledge or clinical competence. Therefore, when there is an absence for a period in excess of six months, the Credentials Committee of the ABA shall determine the number of months of training the resident will have to complete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA examination system.

2.04 ENTRANCE REQUIREMENTS

At the time of application to enter the examination system of the American Board of Anesthesiology, the applicant shall be capable of performing independently the entire scope of anesthesiology practice (see Sections 1.02.A and 1.02.D) and must:

A. Have graduated from a medical school in a state or jurisdiction of the United States or in Canada that was accredited at the date of graduation by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools, or the American Osteopathic Association. Graduates of medical schools outside the jurisdiction of the United States and Canada must have *one* of the following: a permanent (valid indefinitely) certificate from the Educational Commission for Foreign Medical Graduates, comparable credentials from the Medical Council of Canada, or documentation of training for those who entered postdoctoral medical training in the United States via the Fifth Pathway as proposed by the American Medical Association.

B. Provide evidence satisfactory to the Board of having been awarded a medical or osteopathic degree acceptable to the Board.

C. Provide evidence acceptable to the Board of having satisfied the licensure requirement for certification (See Section 2.01.A). The applicant must inform the ABA of any conditions or restrictions in force on any active medical license he or she holds. When there is a restriction or condition in force on any of the applicant's medical licenses, the Credentials Committee of the ABA will determine whether the applicant shall be admitted to the ABA examination system.

Residents in training may submit evidence with their application of having qualified on examinations that provide eligibility for medical licensure (e.g., USMLE Steps 1, 2 and 3). Residents who do so must have evidence of permanent, unconditional, unrestricted and currently unexpired medical licensure on file in the ABA office by November 30 of the year in which the written examination for which they applied is administered.

D. Have on file in the Board office evidence of having satisfactorily fulfilled all requirements of the continuum of education in anesthesiology before the date of examination and after receiving a medical or osteopathic degree acceptable to the ABA. Such evidence must include a satisfactory Certificate of Clinical Competence covering the final six months of Clinical Anesthesia training in each residency

program (see Sections 2.02.C(3) and 2.05 for details). A **grace period** will be permitted so that applicants completing this requirement by August 31 may apply for the immediately preceding July written examination.

E. Have on file with the Board documentation attesting to the applicant's current privileges and evaluations of various aspects of his or her current practice of anesthesiology. Such evaluations will include verification that the applicant meets the Board's clinical activity requirement by spending on average, one day per week, in the clinical practice of anesthesiology and/or related subspecialties. The ABA may solicit such documentation and evaluations from the residency program director or others familiar with the applicant's current practice of anesthesiology and use them in determining the applicant's qualifications for admission to the examination system. The Clinical Competence Committee Report from the department **and** the evaluation of the program director and others will be used as the basis for assessing admission qualifications.

F. If residency training was completed more than 12 years before the date of application, or if a second or subsequent application has been declared void, the applicant must submit proof of having reestablished his or her qualifications for admission to the examination system.

Acceptable proof consists of documentation of having qualified on an entry examination designated by the Board. The Board has designated the examination administered annually by the Joint Council on In-Training Examinations as the entry examination. Information about the entry examination and a registration form may be obtained by writing the Joint Council c/o the American Society of Anesthesiologists. Alternatively, the applicant may complete 12 consecutive months of additional clinical training in anesthesia **as a CA-3 year resident in one ACGME-accredited program** with receipt of a satisfactory Certificate of Clinical Competence covering the final six months.

The applicant must qualify on the entry examination or satisfactorily complete the year of additional training after the date the ABA declared her or his most recent application void. The applicant must complete the requalifying examination before applying to the ABA. If the applicant will complete the year of additional training by August 31, he or she may apply to the ABA for the immediately preceding July written examination. The applicant must apply to the ABA

EXHIBIT J

SUBSPECIALTY CERTIFICATION IN CRITICAL CARE MEDICINE

3.01 DEFINITION OF CRITICAL CARE MEDICINE

The discipline of critical care medicine has evolved over the last few decades in parallel with the development of techniques and technology for acute and long-term life support of patients with multiple organ system derangement. Because the problems encountered in the critically ill patient encompass aspects of many different specialties, critical care medicine is a multidisciplinary endeavor that crosses traditional department and specialty lines.

The critical care medicine physician is a specialist whose knowledge is of necessity broad, involving all aspects of management of the critically ill patient, and whose primary base of operation is the intensive care unit (ICU). This physician has completed training in a primary specialty and has received additional training in critical care medicine aspects of many disciplines. This background enables the physician to work in concert with the various specialists on the patient care team in the ICU; to utilize recognized techniques for vital support; to teach other physicians, nurses, and health professionals the practice of intensive care; and to foster research.

3.02 CERTIFICATION REQUIREMENTS

At the time of subspecialty certification in critical care medicine by the American Board of Anesthesiology, each candidate shall be capable of performing independently the entire scope of anesthesiology critical care medicine practice and must:

A. Be a diplomate of the American Board of Anesthesiology.

B. Fulfill the licensure requirement for certification (see Section 2.01.A).

C. Have fulfilled the requirement of the continuum of education in critical care medicine as defined by the American Board of Anesthesiology.

D. Have satisfied the critical care medicine examination requirement of the American Board of Anesthesiology.

ABA subspecialty certificates in critical care medicine issued on or after January 1, 2000 are valid for ten years after the year the candidate passes the examination for certification. It is left to the holder of the certificate when to apply to the ABA for examination and recertification in the subspecialty.

3.03 THE CONTINUUM OF EDUCATION IN CRITICAL CARE MEDICINE

The continuum of education in critical care medicine consists of 12 months of full-time training in critical care medicine. The training must be in an anesthesiology critical care medicine program in the United States or its territories accredited by the ACGME from the date the training begins to the date it ends. The training must follow completion of the continuum of education in anesthesiology (i.e., Clinical Base and CA 1-3 years) unless the Credentials Committee of the ABA prospectively approves a different training sequence for the resident (see Section 2.02.D for details).

The total of any and all absences during the critical care medicine residency may not exceed the equivalent of 20 working days per year. Attendance at scientific meetings, not to exceed five working days during the year of training, shall be considered part of the training program. Absences in excess of those specified will require lengthening of the total training time to the extent of the additional absence.

Training in critical care medicine must *not* be interrupted by frequent or prolonged periods of absence. When there is an absence for a period in excess of two months, the Credentials Committee of the ABA shall determine the number of months of training the resident will have to complete subsequent to resumption of the residency program to satisfy the training required for admission to the ABA subspecialty examination system.

3.04 ENTRANCE REQUIREMENTS

At the time of application to enter the critical care medicine examination system of the American Board of Anesthesiology, the applicant shall be capable of performing independently the entire scope of anesthesiology critical care medicine practice and must:

A. Be certified by the American Board of Anesthesiology.

B. Submit proof of having fulfilled the licensure requirement for certification (see Section 2.01.A). The applicant must inform the ABA of any conditions or restrictions in force on any active medical license he or she holds. When there is a restriction or condition in force on any of the applicant's medical licenses, the Credentials Committee of the ABA will determine whether the applicant shall be admitted to the ABA examination system.

C. Have on file in the ABA office documentation of having fulfilled the requirement of the continuum of education in critical care medicine.

D. Have on file with the Board documentation attesting to the applicant's current privileges and evaluations of various aspects of the applicant's current practice of anesthesiology critical care medicine. Such evaluations will include verification that the applicant meets the Board's clinical activity requirement by practicing the subspecialty of critical care medicine on average, one day per week. The ABA may use such documentation and evaluations as part of its assessment of the applicant's qualifications for admission to its critical care medicine examination system.

After an applicant has met all of the entrance requirements listed above, the Board shall determine that entry into its critical care medicine examination system is merited when a judgment of clinical competence can be made from the information submitted. The ABA will notify an applicant who is accepted as a candidate for its critical care medicine examination after approval of all credentials.

The Board, acting as a committee of the whole, reserves the right not to accept an application. The applicant has the right to seek review of such decision (see Section 6.05).

The Board reserves the right to correct clerical errors affecting its decisions.

3.05 APPLICATION PROCEDURE

A. The proper **application form** and other information may be obtained from the ABA website or by writing to the Secretary of the American Board of Anesthesiology at the ABA office (see front cover for address). *Telephone requests are not acceptable.*

Application for admission to the examination system of the American Board of Anesthesiology must be made to the Secretary upon a form prescribed by the Board. *Photocopies or facsimiles of the application form are not acceptable.*

B. The application form includes the identical Acknowledgement and Release statements included in the application for primary certification (see Sections 2.06.B and C). The applicant for examination in critical care medicine shall be required to sign each statement.

EXHIBIT K

Q: Does the Board provide in-training examinations for residents?

A: No! The Board concluded over 20 years ago that it should not pretest its potential candidates. An in-service examination of second-year residents is jointly developed and administered each October by the ACP-ASIM, APDIM, and APM to over 18,000 residents (including some first- and third-year residents). The Board does not participate in any aspect of the development, administration, or scoring of this examination. For more information, contact

Ms. Theresa Kanya
Vice President
American College of Physicians-
American Society of Internal Medicine
190 North Independence Mall West
Philadelphia, PA 19106-1572
telephone (215) 351-2400

Q: Who develops the ABIM examination and how?

A: Questions are written by a committee of Board diplomates, including generalists, subspecialists, academicians, and practitioners. Each question is reviewed twice by that group and revised or rejected as appropriate. Diplomates also are invited to submit questions for committee review, revision and selection.

The best of these items are included in the pretest portion of the examination. Pretest questions are not counted as part of the candidateís score, but data are collected concerning candidatesí performance on the items. All pretest items are reviewed by diplomates, who are not Board members, for their assessment of the questionsí relevance to practice.

Finally, Board members select items for the scored portion of the examination. The items selected match the specifications in the blueprint as closely as possible, and are guided by the practitionersí relevance ratings and comments, and the itemís previous performance. This elaborate process ensures that questions have been reviewed and tested rigorously before they are included in a candidateís score.

Q: How does the Board set examination standards?

A: The ABIM uses a modified Angoff standard-setting procedure to select the passing score for its certification and recertification examinations. This procedure, which is widely accepted and supported by an extensive body of published research, has two steps. First, the Board members discuss the characteristics of borderline candidates (i.e., those who are not clearly qualified or unqualified). Second, the Board members estimate the performance of borderline candidates for each item, and these judgments are systematically combined to derive a passing score. The passing standard is independent of the performance of any group of candidates taking the examination.

Q: What are the goals and content of the examination in internal medicine?

A: The goals are to assure competence in the diagnosis and treatment of common conditions that have important consequences for patients, and to assure excellence in the broad domain of internal medicine.

Examination content conforms to a pre-established table of specifications. The blueprint is developed by the Board and reviewed and revised annually to ensure that it is current. The blueprint is based on published studies that describe the kinds of tasks internists actually perform in practice. These data on frequency then are modified to reflect both the breadth of medicine and the importance of various conditions.

Approximately 75% of the questions test knowledge in the traditional specialties of internal medicine. The remaining 25% of the questions are designated to other relevant areas including allergy/immunology, dermatology, gynecology, neurology, ophthalmology, and psychiatry. Independent of primary content, nearly 50% of the questions are chosen to guarantee coverage of content that spans these disciplines. Cross-content areas as covered are listed on the 2001 exam blueprint.

The vast majority of questions are based on patient presentations. The settings of the encounters reflect current medical practice, so about 75% take place in an outpatient or emergency room setting, and the remainder occur in inpatient settings, ranging from the intensive care unit to the nursing home. Questions requiring simple recall of medical facts are in the minority; the majority of items require integration of information from several sources, prioritization of alternatives, and/or utilization of clinical judgment in researching a

correct conclusion.

Q: **What are the content areas for ABIM's 2001 Internal Medicine Certification and Recertification Examinations?**

A: The Internal Medicine Blueprint is as follows:

Primary Content Areas	
Cardiovascular Disease	14%
Gastroenterology	10%
Pulmonary Disease	10%
Infectious Disease	9%
Rheumatology/Orthopedics	8%
Endocrinology	7%
Medical Oncology	7%
Hematology	6%
Nephrology/Urology	6%
Allergy & Immunology	5%
Neurology	4%
Psychiatry	4%
Dermatology	3%
Obstetrics/Gynecology	2%
Ophthalmology	2%
Miscellaneous	3%
	100%
Cross-Content Areas	
Critical Care Medicine	10%
Geriatric Medicine	10%
Prevention	6%
Women's Health	6%
Clinical Epidemiology	3%
Ethics	3%
Nutrition	3%
Palliative/End-of-Life Care	3%
Adolescent Medicine	2%
Occup/Environ Medicine	2%
Substance Abuse	2%

Q: **What does a Board question really ask?**

A: Take a look at the following examples:

1) A 19-year-old white male college student comes to your office complaining of shortness of breath that occurs when he plays basketball or jogs. He has no other complaints and does not smoke cigarettes. Physical examination, complete blood count, and radiograph of the chest are normal.

Which of the following is most likely to be helpful in confirming the suspected diagnosis?

[A] Arterial blood studies before and after exercise
[B] Spirometry before and after exercise
[C] Spirometry before and after administration of bronchodilators
[D] Determination of lung volumes and diffusing capacity measurement of venous blood lactate before and after exercise

2) A 19-year-old Chinese man comes to the emergency room because of urethral discharge. Gram stain shows numerous neutrophils, some of which contain gram-negative intracellular diplococci. Ceftriaxone, 250 mg intramuscularly, is administered. Five days later, the patient comes to your office because the discharge has persisted.
The most likely cause of this discharge is:

[A] Chlamydia trachomatis
[B] Ureaplasma urealyticum
[C] Penicillin-resistant Neisseria gonorrhoeae
[D] Re-infection with Neisseria gonorrhoeae
[E] Urethral stricture

3) A 35-year-old white woman comes to your office because of difficulty reading, which has become noticeable during the past two weeks. She has never required glasses. She takes no medications or other drugs.

The pupils are normal size and react sluggishly to light. Both optic discs appear sharp and there are no hemorrhages or exudates. Visual acuity is strikingly impaired and remains so when the patient uses a pinhole card. Five-beat nystagmus and double vision are noted on left lateral gaze.

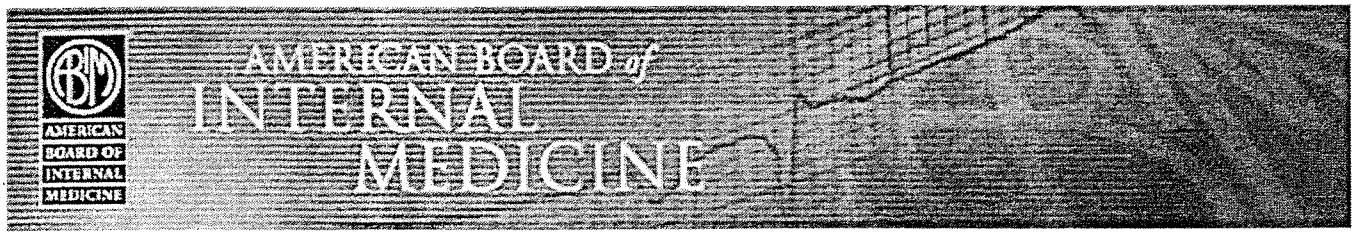
Which of the following is the most likely diagnosis?

[A] Diabetes mellitus
[B] Multiple sclerosis
[C] Myopia
[D] Pseudotumor cerebri
[E] Drug toxicity

4) A previously healthy 75-year-old white woman is brought to your office by her son, who noted that his mother has had a poor appetite, lost at least 4.5 kg (10.0 lb), and been withdrawn for three months. The patient has not had cough or fever, but she tires easily and has been constipated.

The patient appears very subdued, but she responds to questions. Temperature is 37.1 C (98.8F). Pulse rate is 96 per minute, and rhythm is irregular. Blood pressure

EXHIBIT L



Information Booklet
Certification Examination In Internal Medicine

Tuesday and Wednesday
August 19-20, 2003

Publications

The American Board of Internal Medicine
510 Walnut Street, Suite 1700
Philadelphia, PA 19106-3699

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ABIM Web Site: http://www.abim.org

Contents

for training and self-evaluation, (2) assessing the professional credentials of candidates, (3) obtaining substantiation by appropriate authorities of the clinical competence and professional standing of candidates, and (4) developing and conducting examinations for certification and recertification.

The duration of the validity of all certificates issued by the Board in 1990 (1987 for Critical Care Medicine and 1988 for Geriatric Medicine) and thereafter is 10 years, and the dates of validity are noted on the certificates. Certificates issued before these dates will continue to be valid indefinitely.

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GENERAL INFORMATION

Certification In Internal Medicine

Physicians who are awarded a certificate in Internal Medicine must have completed the required predoctoral medical education, met the postdoctoral training requirements, demonstrated clinical competence in the care of patients, met the licensure requirements, and passed the Certification Examination in Internal Medicine.

Predoctoral Medical Education

Candidates from medical schools in the United States or Canada must have attended a school accredited at the date of graduation by the Liaison Committee on Medical Education (LCME), the Committee for Accreditation of Canadian Medical Schools, or the American Osteopathic Association.

Graduates of international medical schools are required to submit either a permanent (valid indefinitely) certificate from the Educational Commission for Foreign Medical Graduates, or comparable credentials from the Medical Council of Canada.

Graduate Medical Education (GME)

To be admitted to the Certification Examination in Internal Medicine physicians must have completed, by August 31 of the year of examination, 36 months of graduate medical education accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada, or the Professional Corporation of Physicians of Quebec. Residency or research experience occurring before the completion of the requirements for the M.D. or D.O. degree cannot be credited toward the Board's requirements.

The 36 months of residency training must include (1) a minimum of 12 months of internal medicine training at the R-1 level, and (2) a minimum of 24 months of training in an accredited internal medicine program, 12 months at the R-2 level and 12 months at the R-3 level.

Content of Training

The 36 months of full-time medical residency education must include the following:

1. At least 30 months of training in general internal medicine, subspecialty internal medicine, critical care medicine, geriatric medicine, and emergency medicine. Up to four months of the 30 months may include training in primary care areas (e.g., neurology, dermatology, office gynecology, or orthopedics);
2. Up to three months of other electives approved by the internal medicine program director; and
3. Up to three months of leave for vacation time, parental leave, or illness. Vacation or other leave cannot be forfeited to reduce training time.

In addition, the following requirements for direct patient responsibility must be met:

EXHIBIT M

American Board of Internal Medicine

2003 CERTIFICATION EXAMINATIONS

Information Booklet

Wednesday, November 5, 2003

Clinical Cardiac Electrophysiology
Critical Care Medicine
Endocrinology, Diabetes, and Metabolism
Gastroenterology
Geriatric Medicine *
Hematology
Infectious Disease
Interventional Cardiology
Medical Oncology
Nephrology
Pulmonary Disease
Rheumatology

Wednesday and Thursday, November 5-6, 2003

Cardiovascular Disease

** developed with The American Board of Family Practice*

CONTENTS

GENERAL INFORMATION

■ TRAINING REQUIREMENTS

No credit will be granted toward certification in a subspecialty or area of added qualifications for training that is not accredited by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada, or the Professional Corporation of Physicians of Quebec.

Fellowship training taken before the date of completion of requirements for the M.D. or D.O. degree, training as a chief medical resident, practice experience, and attendance at postgraduate courses may not be credited toward the requirements for subspecialty certification.

To be admitted to an examination, candidates must have completed the required training in the subspecialty or area of added qualifications by October 31 of the year of examination.

Candidates for certification in the subspecialties and added qualifications must meet the Board's requirements for the total duration of training as well as minimum duration of clinical training. Clinical training requirements may be met by aggregating full-time clinical training that occurs throughout the entire fellowship training period; clinical training need not be completed in successive months. Educational rotations completed during training may not be double counted to satisfy both internal medicine and subspecialty training requirements.

Specific Training Requirements

- *Cardiovascular Disease* – Three years of accredited training, of which a minimum of 24 months is clinical training, in the diagnosis and management of a broad spectrum of cardiovascular diseases. *(Two years of accredited cardiovascular disease fellowship training are required for candidates who initiated fellowship training prior to 1990.)*

- *Gastroenterology* – Three years of accredited training, of which a minimum of 18 months is clinical training, in the diagnosis and management of a broad spectrum of gastroenterological diseases. *(Two years of accredited gastroenterology fellowship training are required for candidates who initiated fellowship training prior to June 1996.)*

- *Adolescent Medicine; Endocrinology, Diabetes, and Metabolism; Hematology; Infectious Disease; Medical Oncology; Nephrology; Pulmonary Disease; and Rheumatology* – Two years of accredited training, of which a minimum of 12 months is clinical training, in the diagnosis and management of a broad spectrum of medical diseases. Additionally, Hematology and Medical Oncology each require experience in an ambulatory care setting and a minimum of one half-day per week spent in a continuity outpatient clinic during the entire two-year training period.

- *Clinical Cardiac Electrophysiology*–See pages 11-13.

- *Critical Care Medicine* –

  Pathway A* – Two years of accredited fellowship training in a subspecialty of internal medicine (three years for cardiovascular disease and gastroenterology), including the care of patients in critical care units.

  Plus

  Certification by ABIM in the subspecialty.

  Plus

  One year of accredited clinical fellowship training in critical care medicine.

  Pathway B – Two years of accredited fellowship training in critical care medicine.

  Pathway C – Two years of fellowship training in advanced general internal medicine that includes at least six months of critical care medicine.

  Plus

  One year of accredited fellowship training in critical care medicine.

  Critical care medicine training must be conducted in an accredited fellowship program that is within the Department of Medicine. The training in critical care medicine must include at least 12 months (up to one month vacation allowed) of appropriately supervised clinical activity directly related to the care of critically ill patients. Clinical activity refers to time spent in meaningful responsibility in the care of patients either as the primary physician, or as a supervising fellow.

  * *ABIM Diplomates who also are certified in Neurology by the American Board of Psychiatry and Neurology may apply through Pathway A provided neurology training included the care of patients in critical care units and the additional year of accredited critical care medicine fellowship training was sponsored by the Department of Internal Medicine*

- *Geriatric Medicine*–One year of accredited clinical fellowship training in geriatric medicine.

- *Interventional Cardiology*–See pages 14-15.

Procedures Required for Certification

- *Cardiovascular Disease* – Advanced cardiac life support (ACLS), including cardioversion; electrocardiography, including ambulatory monitoring and exercise testing; echocardiography; arterial catheter insertion; and right-heart catheterization, including insertion and management of temporary pacemakers.
- *Clinical Cardiac Electrophysiology* – Electrophysiologic studies including mapping, both with a catheter and intraoperatively; surgical and other ablation procedures; and implantation of pacemakers, cardioverters and defibrillators (a minimum of 150 intracardiac procedures in at least 75 patients, of which 75 are catheter ablation procedures, including postdiagnostic testing, and 25 are initial implantable cardioverter-defibrillator procedures, including programming).
- *Critical Care Medicine* – Maintenance of open airway; oral/nasal intubation; ventilator management, including experience with various modes; insertion and management of chest tubes; advanced cardiac life support (ACLS); placement of arterial, central venous, and pulmonary artery balloon-flotation catheters; and calibration and operation of hemodynamic recording systems.
- *Endocrinology, Diabetes, and Metabolism* – Thyroid aspiration biopsy.
- *Gastroenterology* – Proctoscopy and/or flexible sigmoidoscopy; diagnostic upper gastrointestinal endoscopy; colonoscopy, including biopsy and polypectomy; esophageal dilation; therapeutic upper and lower gastrointestinal endoscopy; and liver biopsy.
- *Hematology* – Bone marrow aspiration and biopsy, including preparation, staining, examination, and interpretation of blood smears, bone marrow aspirates, and touch preparations of bone marrow biopsies; measurement of complete blood count, including platelets and white cell differential, using automated or manual techniques with appropriate quality control; administration of chemotherapeutic agents and biological products through all therapeutic routes; and management and care of indwelling venous access catheters.
- *Infectious Disease* – Microscopic evaluation of diagnostic specimens including preparation, staining, and interpretation; management, maintenance, and removal of indwelling venous access catheters; and administration of antimicrobial and biological products via all routes.
- *Interventional Cardiology* – A minimum of 250 therapeutic interventional cardiac procedures during 12 months of acceptable interventional cardiology training.
- *Medical Oncology* – Bone marrow aspiration and biopsy; administration of chemotherapeutic agents and biological products through all therapeutic routes; and management and care of indwelling venous access catheters.
- *Nephrology* – Placement of temporary vascular access for hemodialysis and related procedures; acute and chronic hemodialysis; peritoneal dialysis (excluding placement of temporary peritoneal catheters); continuous renal replacement therapy (CRRT); and percutaneous biopsy of both autologous and transplanted kidneys.
- *Pulmonary Disease* – Oral/nasal intubation; fiberoptic bronchoscopy and accompanying procedures; ventilator management; thoracentesis and percutaneous pleural biopsy; arterial puncture; placement of arterial and pulmonary artery balloon-flotation catheters; calibration and operation of hemodynamic recording systems; supervision of the technical aspects of pulmonary function testing; progressive exercise testing; and insertion and management of chest tubes.
- *Rheumatology* – Diagnostic aspiration of and analysis by light and polarized light microscopy of synovial fluid from diarthrodial joints, bursae, and tenosynovial structures; and therapeutic injection of diarthrodial joints, bursae, tenosynovial structures, and entheses.

■ CLINICAL COMPETENCE REQUIREMENTS

The Board requires documentation that candidates for certification in the subspecialties and added qualifications are competent in patient care (medical interviewing, physical examination, and procedural skills), medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

Through its tracking process, the Board requires verification of the subspecialty fellows' clinical competence from both the subspecialty training program director and the chair of the department of medicine.

All fellows must receive satisfactory ratings of overall clinical competence, and moral and ethical behavior in each of the required years of training.

- Fellows with an unsatisfactory rating in overall clinical competence during any year of training will be required to satisfactorily complete an additional year of accredited fellowship training.
- Fellows with an unsatisfactory rating solely in moral and ethical behavior for any year of training may, at the discretion of the Board, be required to complete additional training and/or a specified period of observation.
- For the final year of required training, fellows with an unsatisfactory rating in any area of clinical competence, including required procedures, must obtain an additional year of accredited training. It is the fellow's responsibility to arrange for any additional training required.

INSTRUCTIONS FOR COMPLETING THE CRITICAL CARE MEDICINE, GERIATRIC MEDICINE, AND SUBSPECIALTY APPLICATIONS

■ APPLICATION FORM

The application form is machine processed. Read all instructions carefully. Use a No. 2 (soft lead) pencil so that you can erase if you make a mistake, or use a pen. Do not fold the application.

1. **Social Security Number**
   Indicate whether you have a U.S. or Canadian social security number. Then print your social security number in the spaces provided and blacken the corresponding ovals under each number.

2. **Date of Birth**
   Blacken the month and fill in the day and the last two digits of the year of your birth; then blacken the corresponding ovals. Be sure to precede a single digit with a zero.

3. **Gender**
   Blacken the appropriate oval.

4. **Test Center**
   Test centers for the examination are listed on page 18. Print the three-digit code numbers for two center choices in order of preference and blacken the corresponding ovals. Write the name of the city beneath each choice. Center assignments are made on a first-come, first-served basis. The earlier the Board receives your application, the more likely it is that you will receive your first choice of examination location. ***No changes in test centers will be processed after September 1, 2003.***

5. **Medical School**
   Write the name, city, state, and country of your medical school. Record the month and year of the start date and degree date of your medical school training.

6. **Licensure**
   All candidates are required to hold a valid, unrestricted, and unchallenged license to practice medicine in the jurisdiction where they practice. List each state, territory, commonwealth, possession, or province of the United States or Canada where you hold a license to practice medicine.

7. **Authorization for Release of Results**
   Your certification status is a matter of public record and is shared with your training program director. In addition, the Board strongly urges you to authorize the release of your individual scores for educational purposes to your program director by blackening the "yes" response.

8. **Professional Standing**
   Please answer these seven questions related to your professional standing by blackening the appropriate response. If the answer to any question is "yes," please append full details and documentation to the application. The Board will seek to confirm your answers from independent sources.

9. **Instructions/Record of Training**
   The Board may already have your fellowship training on file through its tracking program. If so, it will be printed under Item 9 on your application form. Please check the information for accuracy, making any necessary changes directly on the application form. If you have previously applied for this examination, a printed message will appear in this space with instructions on further completion of the application.

10. **Candidate Number**
    This is your permanent number previously assigned to you by the Board.

11. **Name, Address, and Telephone Number**
    It is the policy of the Board to use the full, official names of its candidates and Diplomates. If your full first, middle, and last names are not indicated on the application, please print this information directly on the application. If you prefer that future communications from the Board be mailed to a different address, please provide this information as well. Please record the telephone number where you can be reached during daytime business hours in case the Board has questions about your application.

12. **Application Fee**
    Indicate by blackening the appropriate oval whether you are applying during the regular registration period ($1,130.00) or during the late registration period ($1,430.00). Also indicate in the appropriate oval whether your fee is being paid by check or credit card (VISA or MasterCard only). If you are paying by personal check, money order, or cashier's check, it must be made payable in U.S. funds to the American Board of Internal Medicine. Canadian checks will be accepted if they are made payable in U.S. funds. ***Please write your candidate number as it appears in Item 10 on your check.*** If you are paying by VISA or MasterCard you must provide your full account number as well as the month and year of expiration and blacken the corresponding ovals.

13. **Fellowship Training (Items 13–16)**
    If you have had additional accredited fellowship training which does not appear under Item 9 on your application, please record your training under Items 13 through 16. For each year of training, print the name of the fellowship program in which you trained and the name of your fellowship training program director. See pages 19–23 for a list of accredited training programs and page 18 for the Type of Training codes. Print the four-digit code number of the program in which you trained, the type of training completed, and the beginning and ending dates of the individual year of training and blacken the appropriate ovals. The total number of months per item should not exceed 12 months. If additional space is needed, please append a separate sheet of paper.

17. **Principal Current Hospital/ Practice Organization Appointment(s)**
(Do not complete this section if you are currently completing any formal training.)
If in 2003 you are four years beyond formal training or if you have not been evaluated by the Board since 1999, the Board requires verification that you are recognized as a subspecialist in good standing from the institution(s) where you hold staff appointment(s). Any challenge to good standing must be resolved locally to the Board's satisfaction before admission to the examination. For example, substance abuse, criminal convictions related to medical practice, or substantial disciplinary action by the institution may lead to deferred admission or rejection from examination.

    If applicable, Forms Attesting Current Appointment have been included with your application. ***You are required to have the individuals listed under Item 17 complete and return the forms to the Board office.*** Postage-paid envelopes have been included to expedite the return of the forms. *(Please note: If needed, extra forms are available upon request. However, it is not necessary that all four forms be returned if your practice does not involve four hospitals.)*

18. **Current Status**
If you completed formal training prior to July 1, 1999 and do not hold a hospital staff appointment, this item must be completed. If required, provide two letters of support from ABIM Diplomates who can attest to your current good standing.

19. **Signature and Date**
Please read the APPLICATION STATEMENT below before signing and dating your application. Print your full official first, middle, and last names in the spaces provided. Failure to provide this information will delay the processing of your application.

APPLICATION STATEMENT

I hereby make application to THE AMERICAN BOARD OF INTERNAL MEDICINE (the "Board") for admission to examination leading to the issuance of the appropriate Diplomate Certificate all in accordance with and subject to the Board's rules and policies. I agree to pay the fee to cover the review of my credentials and the examination, of which all but One Hundred Twenty-Five Dollars ($125) will be refunded if this application is disapproved.

I agree that the Board shall be the final judge of my credentials and qualifications for admission to the examination and for certification. I agree that the Board may disqualify me from the examination, from certification or may cancel my certification and require the return of the Diplomate Certificate in the event that the Board determines (1) that any information furnished by me is false, or (2) that I violated the Board's rules and policies in connection with my application or the examination.

I agree that irregular or improper behavior during the examination, such as giving or obtaining unauthorized information or aid, looking at the test materials of other candidates, removing an examination book from the test center, taking notes, bringing electronic devices (e.g., beepers, pagers, cellular phones, etc.) into the examination, failing to comply with proctors' instructions, disregarding time limits, talking, or other disruptive behavior, will be considered an attempt to subvert the certification process. These and other irregular or improper behaviors, as evidenced by observation, by subsequent statistical analysis, or by other means, may be sufficient cause for the Board to terminate my participation in the examination, to invalidate the results of my examination, to bar me from admission to future examinations or from certification, and to take other appropriate actions, including informing licensing bodies, law enforcement agencies, my program director(s), or others.

I understand that the examination is confidential and copyrighted. I agree not to copy, reproduce, reconstruct by dictation or other means, or disclose examination content in any manner.

I understand that the Board makes academic and scientific judgments in its evaluations of the results of its examinations, and that situations may occur, even through no fault of mine, that will render my examination results unreliable in the judgment of the Board. I agree that if the Board determines that, in its judgment, the results of my examination are unreliable, the Board may require me to retake the examination at its next administration or other time designated by the Board.

I agree that my professional qualifications, including my moral and ethical standing in the medical profession and my competence in clinical skills, will be evaluated by the Board and that the Board may make inquiry of the persons named in my application and of other persons, such as authorities of licensing bodies, hospitals, or other institutions as the Board may deem appropriate with respect to such matters. I agree that the Board may provide information it has concerning me to others whom the Board judges to have a legitimate need for it.

I agree to indemnify, release, and hold harmless the Board, its Subspecialty Boards, its members, employees, officers, agents, and those furnishing information about me to the Board from any liability or damage by reason of any of their acts or omissions, done in good faith, in connection with this application, information furnished to the Board, the evaluation of my qualifications, or the administration and scoring of my examination.

I understand that my individual examination scores will be considered to be confidential except that the Board may use my scores for research under appropriate conditions of confidentiality established by the Board.

I hereby declare under penalty of perjury that the information given in my application is true and correct to the best of my knowledge and belief. I agree to be legally bound by the foregoing.

EXHIBIT N

Resources for the Public

WHAT ARE OBSTETRICIANS AND GYNECOLOGISTS?

Obstetrician-gynecologists specialize in the general medical care of women, as well as care related to pregnancy and the reproductive tract.

WHAT TRAINING IS REQUIRED AND WHAT IS COVERED?

The obstetrician-gynecologist goes through four years of specialized residency training in areas dealing with preconceptional health, pregnancy, labor and childbirth, postpartum care, genetics, genetic counseling and prenatal diagnosis.

Training in gynecology also covers women's general health, including care of reproductive organs, breasts and sexual function.

Screening for cancer at multiple sites is performed or initiated by the Ob-Gyn specialist.

Gynecology also includes management of hormonal disorders, treatment of infections, and training in surgery to correct or treat pelvic organ and urinary tract problems to include cancer of the reproductive organs.

During four years of training, the obstetrician-gynecologist learns about aspects of preventive health care, including exams and routine tests that look for problems before you are sick, immunizations, overall health and provision of care for a range of medical problems, not just those of the reproductive system.

CERTIFICATION IN OBSTETRICS AND GYNECOLOGY

After residency, a physician may seek certification from the American Board of Obstetrics and Gynecology.

To become Board certified, a physician must pass a written test to demonstrate that he or she has obtained the special knowledge and skills required for medical and surgical care of women.

He or she must also show experience in treating women's health care prior to the oral examination.

The oral examination is given by a team of well-respected national experts; the exam tests the physician's skills, knowledge and ability to treat different conditions. The examiners also review the patients the physician treated during the past year.

MAINTENANCE OF CERTIFICATION

Physicians certified after 1986 must be recertified at periodic intervals in order to

QUESTIONS WE CAN'T ANSWER

FREQUENTLY ASKED QUESTIONS FOR THE PUBLIC AND MEDICAL ORGANIZATIONS

FIND OUT IF A DOCTOR IS CERTIFIED

FIND AN OBSTETRICIAN OR GYNECOLOGIST

TRAINING AND CERTIFICATION OF OBSTETRICIAN - GYNECOLOGISTS AND SUBSPECIALISTS

RESOURCES ON THE WEB FOR WOMEN, THEIR FAMILIES AND FRIENDS

CAUTION ON ACCURACY

ALLIED AND RELATED ORGANIZATIONS

OTHER RESOURCES

Search

Advanced Search

maintain their certification.

TRAINING AND CERTIFICATION IN SUBSPECIALTIES

Board-certified obstetrician-gynecologists may become further specialized in the areas of:

- maternal-fetal medicine (care of high-risk pregnancy),
- gynecologic oncology (care of women with cancers of the reproductive system),
- reproductive endocrinology and infertility (care of women who have hormonal or infertility problems), and
- female pelvic medicine and reconstructive surgery (care of urinary tract dysfunction and disorders stemming from loss of support of pelvic structures).

This extra training and certification requires three years of training after a basic residency, and the passing of both a written and oral examination.

All certified obstetrician-gynecologists can treat patients with these disorders; however, some physicians have this extra training that qualifies them to take a written and oral test to be certified in these areas.

Next: RESOURCES ON THE WEB FOR WOMEN, THEIR FAMILIES AND FRIENDS

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Basic Certification of Obstetricians and Gynecologists

CERTIFICATION IN CRITICAL CARE

On September 18, 1985, The American Board of Obstetrics and Gynecology, Inc. was authorized to issue certificates in Obstetrics and Gynecology with **Added Qualification** in Critical Care.

The purpose of certifying in Critical Care is to recognize those Obstetricians/Gynecologists who through added education and examination have demonstrated added knowledge and skill in the care of critically ill patients.

An individual who meets the requirements will be issued a certificate in Obstetrics and Gynecology with added qualification in Critical Care by The American Board of Obstetrics and Gynecology, Inc.

Certificates will bear a date limiting their initial validity to six (6) years. A program for renewal certificates will be established.

Requirements

The following qualifications are required for applicants for certification.

1. Certified Diplomate of The American Board of Obstetrics and Gynecology, Inc.

2. Each candidate must be in good standing with the Board.

3. Satisfactory completion of education in Critical Care of no less than 12 months full-time duration.

This education must be in a program fulfilling the requirements of The American Board of Surgery for Surgical Critical Care or the requirements of The American Board of Anesthesiology for Critical Care Medicine. These requirements also must be acceptable to The American Board of Obstetrics and Gynecology, Inc.

4. The credentials and training of the candidate must be approved by The American Board of Obstetrics and Gynecology, Inc. prior to admission to the examinations in Surgical Critical Care or Critical Care Medicine.

Applications must be received at least six months prior to the date of the examination.

5. Successful completion of the examination in Surgical Critical Care administered by The American Board of Surgery or the examination in Critical Care Medicine administered by The American Board of Anesthesiology.

THE ORAL EXAMINATION

LISTING OF CERTIFIED DIPLOMATES

REVOCATION OF DIPLOMA OR CERTIFICATE

APPEALS

OTHER CONSIDERATIONS

CERTIFICATION IN CRITICAL CARE
Requirements
Application Procedure

Search
Advanced Search

Application Procedure

1. A candidate intending to make application for certification of added qualification in Critical Care must notify the Board Office at least six months prior to the anticipated start of education in Critical Care.

This letter of intent must be accompanied by a non-refundable **registration** fee of $400.00.

2. The Board Office of The American Board of Obstetrics and Gynecology must receive an affidavit from the program director of the Critical Care program attesting to the candidate's satisfactory completion of the program.

3. Application for certification in Critical Care must be made at least 6 months prior to the date of examination. The **application fee** is $600.00 and must accompany the application.

4. The examination may be taken at the conclusion of the education in Critical Care contingent upon availability of examination by either The American Board of Surgery or The American Board of Anesthesiology, but the examination must be from the Board which approved the fellowship program where the candidate received education.

5. The Surgery or Medicine Board must submit a statement on behalf of the candidate indicating that the candidate is in good standing with the Board.

6. Time spent in a critical care fellowship cannot be used to meet the practice requirements for eligibility to take the principal oral examination in Obstetrics and Gynecology.

7. All respondents should make application to the Executive Director of The American Board of Obstetrics and Gynecology, Inc.

Next: SUMMARY OF DATES, DEADLINES, FEES AND LATE FEES FOR 2002 EXAMINATIONS

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ABOG Leaders

EXHIBIT O

Board Certification

The ABP's certificate in General Pediatrics is awarded after all the following requirements have been met:

- GRADUATION from an accredited medical school in the United States or Canada or from a foreign medical school recognized by the World Health Organization.
- COMPLETION of three years of training in pediatrics in an accredited residency program. This training involves the care of children and adolescents in hospital and outpatient settings and is supervised by highly trained medical specialists.
- VERIFICATION of satisfactory completion of residency training and acceptability as a practitioner of pediatrics, including the achievement of clinical competence and the demonstration of professional and ethical behavior.
- POSSESSION of a valid, unrestricted state license to practice medicine.
- SUCCESSFUL completion of a comprehensive two-day written examination covering all aspects of health care for infants, children, and adolescents.

Subspecialists may earn certification in their field after three additional years of training in a focused area such as pediatric infectious diseases. They must be evaluated and recommended by someone qualified to judge their work, and they must pass a demanding examination in their subspecialty.

As of 1988, certificates issued by the ABP are time-limited. To remain Board-certified, pediatricians with time-limited certificates must present evidence of licensure and pass an examination every seven years. This recertification process recognizes the ABP's commitment to professionalism and its belief that lifelong scholarship and self-evaluation are required for high-quality medical care.

A Board-certified pediatrician possesses a certificate from the ABP and is referred to as a "Diplomate" of the ABP. More detailed information on certification is available under Certification Information.

The certification status of individuals certified by the ABP is available at our Verification of Certification page.

Information about certification status can also be obtained by calling the ABP at 919-929-0461 or the American Board of Medical Specialties (ABMS) at 1-888-ASK-ABMS (275-2267). Certified specialists are also listed under Who's Certified at www.abms.org and in directories published by the ABMS. These include individual directories for each specialty and *The Official ABMS Directory of Board Certified Medical Specialists*, which can be found in many public and university libraries, hospital libraries, and medical school libraries.

Eligibility Criteria for Certification in Pediatric Critical Care Medicine

(Published August 2002)

The ABP has established a procedure for certification in pediatric critical care medicine. In addition to the specific admission requirements listed below, there are general eligibility criteria that must be fulfilled to be eligible for certification.

It should be noted that these criteria are subject to change without notice. All applicants are advised to contact the ABP to ascertain whether the information they have is current.

Admission Requirements

Physicians who entered training in pediatric critical care medicine on or after January 1, 1992, are required to complete their training in a program accredited for training in pediatric critical care medicine by the RRC for Pediatrics in the United States or RCPSC in Canada.

A subspecialty fellow who entered pediatric critical care medicine training before January 1, 1988, may apply for admission on the basis of completion of 2 years of fellowship training in pediatric critical care medicine. A subspecialty fellow who is certified in anesthesiology by the American Board of Anesthesiology may apply for admission on the basis of completion of 2 years of subspecialty fellowship training in pediatric critical care medicine. Only those pediatric critical care medicine training programs that were operated in association with general comprehensive pediatric residency programs accredited by the RRC or by the RCPSC are acceptable.

Three years of full-time, broad-based subspecialty fellowship training in pediatric critical care medicine is required for fellows entering training on or after January 1, 1988. Combined absences/leave in excess of 3 months during the 3 years of training, whether for vacation, parental leave, illness, etc, must be made up. If the program director believes that combined absences/leave that exceeds 3 months is justified, a letter of explanation should be sent by the director for review by the Credentials Committee.

For a fellow who began pediatric critical care medicine training on or after January 1, 1988, the following must be accomplished in order to become certified in the subspecialty: a Verification of Competence Form must be completed by the program director(s) stating satisfactory completion of the required training as well as verification of clinical competence and meaningful accomplishment in research; the fellow must meet the criteria stated in the "Principles Regarding the Assessment of Meaningful Accomplishment in Research"; and he/she must pass the subspecialty certifying examination.

A fellow beginning part-time training after January 1, 1988, may complete the required training on a part-time basis not to exceed 6 years. No continuous absence of more than 1 year will be permitted.

EXHIBIT P

THE AMERICAN BOARD OF SURGERY
Incorporated

1617 John f. Kennedy
Boulevard
Suite 860
Philadelphia, PA 19103
Phone: (215) 568-4000
Fax: (215) 563-5718

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Specialty of Surgery Defined

The Board interprets the term "General Surgery" in a comprehensive yet specific manner, as a discipline having a central core of knowledge embracing anatomy, physiology, metabolism, immunology, nutrition, pathology, wound healing, shock and resuscitation, intensive care and neoplasia, which are common to all surgical specialties. A General Surgeon certified by the American Board of Surgery is one who has acquired during training knowledge and experience related to the diagnosis, preoperative, operative, and postoperative management, including the management of complications, in the essential content areas listed below. Experience in any of these content areas does not necessarily encompass its full range and complexity of procedures, particularly advanced operations and treatments of a specialized nature. This is especially true of disciplines that have ACGME-approved residencies beyond General Surgery residencies and mechanisms for additional certification. The following content areas are essential in the comprehensive education of a broadly based surgeon:

- Alimentary Tract Abdomen and its Contents
- Breast, Skin and Soft Tissue
- Endocrine System
- Head and Neck Surgery
- Pediatric Surgery
- Surgical Critical Care Surgical
- Oncology Transplantation
- Surgery Trauma/Burns
- Vascular Surgery

Additionally, the General Surgeon is expected to have had preoperative, operative and postoperative experience in Plastic and Cardiothoracic Surgery, and must have an understanding of the management of the more common problems in Gynecologic, Neurologic, Orthopaedic, and Urologic Surgery and of the administration of anesthetic agents. In addition, the

surgeon must be familiar with the unique requirements of the geriatric surgical patient and must have knowledge and skills in palliative care, including operative care, counseling patients and families, and management of pain, cachexia and weight loss. The General Surgeon must have had significant experience in performing minimally invasive surgical procedures. The General Surgeon must also be capable of employing endoscopic techniques, particularly proctosigmoidoscopy, colonoscopy, esophagogastroduodenoscopy, laparoscopy, and operative choledochoscopy, and must have experience in other relevant diagnostic and therapeutic techniques including laryngoscopy, bronchoscopy, and fine needle aspiration. The General Surgeon should also have experience with sentinel lymph node mapping and biopsy techniques for breast cancer and melanoma, and have the opportunity to become familiar with evolving diagnostic and therapeutic methods, including the following:

- Investigation and manipulation of the distal common bile duct (including sphincterotomy).
- Stereotactic breast biopsy techniques, including advanced breast biopsy instrumentation (ABBI), core needle biopsy, and mammotome techniques.
- Physiologic testing and evaluation of the GI tract.
- Diagnostic ultrasonography of the following areas:
    - Head and Neck
    - Breast
    - Abdomen, including intraoperative and laparoscopic ultrasound
    - Endorectal
    - Non-invasive diagnostic evaluation of the vascular system and invasive vascular interventional techniques.

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Examinations Offered By The Board

General Surgery

1. Qualifying (Written) Examination
2. Certifying (Oral) Examination
3. Recertification Examination
4. In-Training/Surgical Basic Science Examination

Pediatric Surgery

1. Qualifying (Written) Examination
2. Certifying (Oral) Examination
3. Recertification Examination
4. In-Training Examination

Vascular Surgery

1. Qualifying (Written) Examination
2. Certifying (Oral) Examination
3. Recertification Examination

Surgical Critical Care

1. Certifying (Written) Examination
2. Recertification Examination

Surgery of The Hand

1. Certifying (Written) Examination
2. Recertification Examination

EXHIBIT Q

Society of Critical Care Medicine

The Intensive Care Professionals

April 25, 2003

Internal Medicine

RELATED LINKS

Section Update

Governance

Accredited Programs

Internal Medicine is the branch of medicine that diagnoses and non-surgically treats diseases affecting the internal organs of the body. The Internal Medicine Section of the Society of Critical Care Medicine provides a forum for discussion and action on issues of importance to internal medicine intensivists.

The Internal Medicine Section is the largest Section of the Society of Critical Care Medicine, accounting for approximately 32% of SCCM membership.

Internal Medicine Section members contribute to both the Section and SCCM at large. Many members exhibit active involvement and assertive leadership through Section committees, including Bylaws, Education, Research, Membership, Communication and Public Policy. In addition to a designated seat on the Council, the Internal Medicine Section is represented on many of SCCM's important committees, such as Advocacy, Strategic Planning, Research and Program Development. For supplementary information on the Internal Medicine Section, please contact:

Jonathan Warren, MD, FCCM
President
Augusta, Georgia
Jwarrenmd@aol.com

Section membership is extended to any U.S or international intensivist specializing in internal medicine.

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Page last updated: 03/28/03 12:26:15 PM

Society of Critical Care Medicine

The Intensive Care Professionals

April 25, 2003

Anesthesiology

Please join Anesthesiology Section members for an interim Advisory Board meeting during the ASA annual meeting in Orlando on Saturday, Oct 12th from 9:15-10:15 am, Room 232-A in the Orlando Convention Center.

RELATED LINKS

Governance

Accredited Programs

Shubin-Weil Award Winners

SCCM Past Presidents

Criteria for Burchardi Award

The Burchardi Award is an award that is jointly sponsored by the American Society of Critical Care Anesthesiologists and the Society of Critical Care Medicine's Anesthesiology Section. It was named after its first recipient, Dr. Hilmar Burchardi, a pioneer in the field, a revered teacher and founding member of the European Society of Intensive Care Medicine, which he presided over 1998-2000. The award was first established in 2002 at the SCCM Annual Congress and will be presented every two years, alternately at an ASCCA or SCCM event.

Criteria for nomination:

The individual should be an anesthesia-based intensivist, who has been practicing for at least 12 years and who has held a leadership position in at least one of the established national or international critical care societies/organizations. He/she should have made considerable contributions to the specialty, not necessarily in terms of research, but especially in terms of ability to motivate and touch people. His/her greatness and leadership should be defined equally by competence, humility, humanity, and a sense of humor; in short, this is a "Good Guy/Good Gal" award.

Nominees should be members of at least one, preferably both sponsoring organizations and should have at least two letters of support from members of the societies. Nominations and letters of recommendation and support are due to the President of ASCCA and to the Chair of the SCCM Anesthesiology Section by September 15th of odd years starting in 2003. This will allow the respective Boards to deliberate and vote on the matter when they convene in October of that year.

Please submit nominations for the 2004 award with supporting letters to each, Dr. Clifford Deutschman, President of ASCCA and Dr. Eugene Cheng, Chair of the SCCM Anesthesiology Section by this coming September 15th. Thank you.

Section Mission

The mission of the anesthesiology section is to represent, promote and educate anesthesiologist/intensivists as team leaders of the multi-professional team model of patient-centered care for all critically ill patients. In addition, the Section seeks to help educate non-

anesthesiologist/intensivists regarding the value and role of the anesthesiologist/intensivist within the specialty of critical care medicine.

Section Core Values:

High quality patient care: We seek to provide an evidence-based structure and process for the care of the critically ill. Our care should be safe, effective, efficient, patient centered, timely, and equitable. Our approach is metric and outcomes driven. We continually strive to refine and refocus our efforts to improve patient outcomes and care.

An educational environment: We believe that the best care is delivered in an educational environment.

Discovery: We seek explanations for clinically relevant problems and strive to find and develop new and innovative solutions so that our patients are assured of receiving leading-edge care.

Patient, family and surrogate satisfaction: We strive to identify all patients, family members and surrogates and to attempt to understand and honor their value. We pledge to measure and monitor levels of satisfaction with the care we provide, and continually improve service satisfaction.

Ethical Practice: We value reliability, trust and integrity in all aspects of our work.

Safety: We strive to create a culture of safety.

For information on how to become a member of the Anesthesiology Section, please send an email to SCCM at info@sccm.org.

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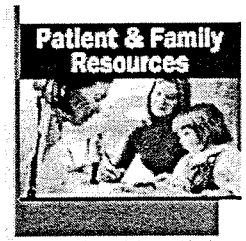
Society of Critical Care Medicine
The Intensive Care Professionals
April 25, 2003



Internal Medicine: Accredited Programs

Accreditation Council for Graduate Medical Education

List of programs within a particular specialty for current academic year and those newly accredited programs with future effective dates
(Year ending June 30th, 2003)

Internal Medicine- Critical Care Medicine

Program Number/ Name / Address	Specialty	Director	Phone Fax/ Email
[1420511005] Cedars-Sinai Medical Center Program Cedars-Sinai Medical Center 8700 Beverly Boulevard Los Angeles, CA 90048-0342	Critical Care Medicine (IM)	Lawrence S. Maldonado, MD	(310)42 4684 (310)42 0436
[1420521013] Stanford University Program Stanford University Medical Center 300 Pasteur Drive, Room C-356 Stanford, CA 94305-5236	Critical Care Medicine (IM)	Norman W. Rizk, MD	(650)72 6381
[1420511007] UCLA Medical Center Program UCLA Department of Medicine Center for the Health Sciences 10833 LeConte Avenue Los Angeles, CA 90095-1690	Critical Care Medicine (IM)	Robert M. Strieter, MD	(310)79 9870 (310)2C 8622
[1420521011] University of California (San Francisco) Program University of California Dept of Medicine Box 0624 San Francisco, CA 94143-0624	Critical Care Medicine (IM)	Michael A. Matthay, MD	(415)3E 1206 (415)3E 1990
[1421021103] George Washington University Program George Washington University Medical Center 901 23rd Street, NW Washington, DC 20037	Critical Care Medicine (IM)	Michael G. Seneff, MD	(202)71 4591
[1421021125] National Capital Consortium (Walter Reed) Program	Critical Care Medicine	Thomas M. Fitzpatrick, MD	(202)78 2782

Walter Reed Army Medical Center 6825 16th Street, NW Washington, DC 20307-5001	(IM)		
[1421121020] Jackson Memorial Hospital/Jackson Health System Program University of Miami-Jackson Memorial Medical Center Department of Medicine (D-26) P.O. Box 016760 Miami, FL 33101	Critical Care Medicine (IM)	Roland M H Schein, MD	(305)32 3153 (305)32 3366
[1421621026] Finch University of Health Sciences/Chicago Medical School Program Finch University of Health Sciences/Chicago Medical School Department of Medicine-Division of Critical Care Medicine 3333 Green Bay Road North Chicago, IL 60064-5001	Critical Care Medicine (IM)	Eric Gluck, MD	(773)29 3200
[1421611027] Rush-Presbyterian-St Luke's Medical Center Program Rush-Presbyterian-St. Luke's Medical Center 1653 West Congress Parkway Chicago, IL 60612	Critical Care Medicine (IM)	Robert A. Balk, MD	(312)94 2998 (312)94 5829
[1421611024] University of Chicago Program The University of Chicago Department of Medicine 5841 S. Maryland Avenue Chicago, IL 60637	Critical Care Medicine (IM)	Gregory Schmidt, MD	(773)70 1856 (773)70 6500
[1422121032] Louisiana State University (Shreveport) Program Louisiana State University Medical Center 1501 Kings Highway Shreveport, LA 71130-3932	Critical Care Medicine (IM)	Steven A. Conrad, MD, PhD	(318)67 6885 (318)67 7811
[1422421035] University of Massachusetts Program University of Massachusetts Medical School 55 Lake Avenue, North Worcester, MA 01655-3932	Critical Care Medicine (IM)	Nicholas A. Smyrnios, MD	(508)85 3122
[1422321128] National Institutes of Health Clinical Center Program National Institutes of Health Building 10, Room 07-D-43 Bethesda, MD 20892	Critical Care Medicine (IM)	Frederick P. Ognibene, MD	(301)49 9320
[1422621118] Hennepin	Critical	James W.	(612)34

County Medical Center Program Hennepin County Medical Center 701 Park Avenue Minneapolis, MN 55415-3932	Care Medicine (IM)	Leatherman, MD	2625 (612)9C 4680
[1422621100] Mayo Graduate School of Medicine (Rochester) Program Mayo Graduate School of Medicine 200 First Street, SW Rochester, MN 55905-3932	Critical Care Medicine (IM)	William Dunn, MD	(507)2E 3275
[1422821048] St Louis University School of Medicine Program St. John's Mercy Medical Center 621 S. New Ballas Road Suite 4006B St. Louis, MO 63141	Critical Care Medicine (IM)	Robert W. Taylor, MD	(314)5E 6486 (314)9S 4155
[1423621069] Wake Forest University School of Medicine Program Wake Forest University School of Medicine Medical Center Boulevard Winston Salem, NC 27157-1009	Critical Care Medicine (IM)	Drew A. MacGregor, MD	(336)71 4498 (336)71 9534
[1423221140] Dartmouth-Hitchcock Medical Center Program Dartmouth-Hitchcock Medical Center One Medical Center Drive Lebanon, NH 03756	Critical Care Medicine (IM)	Howard L. Corwin, MD	(603)6E 4642 (603)6E 0614
[1423311050] Seton Hall University School of Graduate Medical Education Program St. Michael's Medical Center 306 M L King Boulevard Newark, NJ 07102-3932	Critical Care Medicine (IM)	Marc R. Adelman, MD	(201)87 5090 (973)87 2737
[1423321051] UMDNJ-Robert Wood Johnson Medical School (Camden) Program Cooper Hospital/University Medical Center Three Cooper Plaza, Suite 220 Camden, NJ 08103-3932	Critical Care Medicine (IM)	Richard P. Dellinger, MD	(856)34 2633 (856)54 2357
[1423421053] University of New Mexico Program University of New Mexico Health Sciences Center 2211 Lomas Boulevard, NE, 5-ACC	Critical Care Medicine (IM)	Helen K. Busby, MD	(505)27 4751

Albuquerque, NM 87131-5271			
[1423521067] Albert Einstein College of Medicine Program Montefiore Medical Center 111 East 210th Street Bronx, NY 10467	Critical Care Medicine (IM)	Vladimir Kvetan, MD	(718)92 5440 (718)65 2464
[1423511056] Maimonides Medical Center Program Maimonides Medical Center 4802 Tenth Avenue Brooklyn, NY 11219	Critical Care Medicine (IM)	Sidney Tessler, MD	(718)28 8380 (718)28 7884
[1423521064] Memorial Sloan-Kettering Cancer Center/New York Presbyterian Hospital (Cornell Campus) Program Memorial Sloan-Kettering Cancer Center 1275 York Avenue New York, NY 10021	Critical Care Medicine (IM)	Jeffrey S. Groeger, MD	(212)79 8114 (212)79 4333
[1423531060] Mount Sinai School of Medicine Program Mount Sinai Medical Center Box 1264 One Gustave L Levy Place New York, NY 10029-6574	Critical Care Medicine (IM)	John M. Oropello, MD	(212)24 7331 (212)86 3669
[1423511058] New York Medical College at St. Vincent's Hospital and Medical Center of New York Program St. Vincent's Hospital and Medical Center of New York 153 West 11th Street New York, NY 10011	Critical Care Medicine (IM)	Mark E. Astiz, MD	(212)60 8336 (212)60 8061
[1423521065] SUNY Health Science Center at Brooklyn Program SUNY-Downstate Medical Center 450 Clarkson Avenue, Box 19 Brooklyn, NY 11203	Critical Care Medicine (IM)	Spiro Demetis, MD	(718)27 1770 (718)27 1733
[1423521141] University of Rochester Program Strong Memorial Hospital Pulmonary & Critical Care Division 601 Elmwood Avenue. Box 692 Rochester, NY 14642	Critical Care Medicine (IM)	Michael J. Apostolakos, MD	(716)27 2050 (716)27 1126
[1564021061] Oregon Health & Science University Program Oregon Health & Science University Pulmonary & Critical Care Medicine Fellowship Program 3181 SW Sam Jackson Park Road, UHN 67	Critical Care Medicine (IM)	Dane Nichols, MD	(503)494 7680 (503)494 6670

Portland, OR 97239-3098			
[1424121114] University Health Center of Pittsburgh Program University of Pittsburgh Medical Center Veterans Affairs Medical Center University Drive C Pittsburgh, PA 15240-1009	Critical Care Medicine (IM)	Paul L. Rogers, MD	(412)64 3135 (412)64 8060
[1424311083] Brown University Program Miriam Hospital 164 Summit Avenue, Suite 221 Providence, RI 02906-1009	Critical Care Medicine (IM)	Paul C. Yodice, MD	(401)79 4501 (401)79 4511
[1424821091] Baylor College of Medicine Program Baylor College of Medicine/Ben Taub General Hospital Pulmonary & Critical Care Medicine Section 1504 Taub Loop, 6th Floor Houston, TX 77030	Critical Care Medicine (IM)	Kalpalatha K. Guntupalli, MD	(713)87 2468 (713)79 9576
[1425421094] University of Washington Program University of Washington Medical Center Box 356522 1959 NE Pacific Street Seattle, WA 98195	Critical Care Medicine (IM)	Mark R. Tonelli, MD, MA	(206)68 8946

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Society of Critical Care Medicine
The Intensive Care Professionals
April 25, 2003

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Anesthesiology: Accredited Programs

Accreditation Council for Graduate Medical Education

List of programs within a particular specialty for current academic year and those newly accredited programs with future effective dates
(Year ending June 30th, 2003)

Anesthesiology Critical Care Medicine

Program Number / Name / Address	Specialty	Director	Phone/ Fax/ Email
[0450112067] University of Alabama Medical Center Program University of Alabama at Birmingham 619 S. 19th Street, JT 845 Birmingham, AL 35249-6810	Critical Care Medicine (AN)	Philip J. McArdle, MD	(205)934-4699 (205)975-5963
[0450321046] University of Arizona Program University of Arizona Health Sciences Center 1501 N. Campbell Avenue P.O. Box 245114 Tucson, AZ 85724-5114	Critical Care Medicine (AN)	Charles W. Otto, MD	(520)626-7221 (520)626-6943
[0450521002] Stanford University Program Stanford University School of Medicine Department of Anesthesia, H 3580 300 Pasteur Drive Stanford, CA 94305-5640	Critical Care Medicine (AN)	Myer H. Rosenthal, MD	(650)723-6415 (650)725-8544
[0450521011] University of California (Irvine) Program University of California, Irvine, Medical Center Veterans Affairs Medical Center 5901 E. Seventh Street (139) Long Beach, CA 90822	Critical Care Medicine (AN)	Elizabeth Behringer, MD	(714)456-5501 (310)494-5991
[0450521021] University of California (San Francisco) Program University of California, San Francisco, Medical Center	Critical Care Medicine (AN)	Linda Liu, MD	(415)353-1116

Box 0624 505 Parnassus Avenue San Francisco, CA 94143			
[0450821035] University of Connecticut Program Hartford Hospital 80 Seymour Street P.O. Box 5037 Hartford, CT 06102-5037	Critical Care Medicine (AN)	Thomas C. Mort, MD	(860)545-5201 (860)545-3266
[0450821058] Yale-New Haven Medical Center Program Yale-New Haven Medical Center 333 Cedar Street P.O. Box 208051 New Haven, CT 06520-8051	Critical Care Medicine (AN)	Stanley H. Rosenbaum, MD	(203)785-2802 (203)785-6664
[0451021039] George Washington University Program George Washington University Medical Center 901 23rd Street, NW Washington, DC 20037	Critical Care Medicine (AN)	Christopher D. Junker, MD	(202)994-3134 (202)994-4800
[0451021042] National Capital Consortium Program Walter Reed Army Medical Center Critical Care Medicine 6900 Georgia Avenue NW Washington, DC 20307-5001	Critical Care Medicine (AN)	Christian Popa, MD	(202)782-2066 (202)782-5043
[0451121004] Jackson Memorial Hospital/Jackson Health System Program University of Miami School of Medicine Division of Trauma Anesthesia and Critical Care P.O. Box 016370 (M820) Miami, FL 33101	Critical Care Medicine (AN)	Albert J. Varon, MD	(305)585-1191 (305)545-6195
[0451121009] University of Florida Program University of Florida Medical Center JHMMC P.O. Box 100254 Gainesville, FL 32610-0254	Critical Care Medicine (AN)	T. James Gallagher, MD	(352)265-0463 (352)338-9861
[0451121050] University of South Florida Program University of South Florida College of Medicine MDC 59 12901 Bruce B Downs Boulevard Tampa, FL 33612	Critical Care Medicine (AN)	John B. Downs, MD	(813)844-7348 (813)844-7418
[0451221059] Emory University Program	Critical Care	James M. Bailey, MD, PhD	(404)778-3917

Emory University Hospital 1364 Clifton Road, NE Atlanta, GA 30322	Medicine (AN)		(404)778-3940
[0451821003] University of Iowa Hospitals and Clinics Program University of Iowa Hospitals and Clinics 200 Hawkins Drive Iowa City, IA 52242	Critical Care Medicine (AN)	J. Steven Hata, MD	(319)356-0772 (319)356-1120
[0451621014] McGaw Medical Center of Northwestern University Program Northwestern University Feinberg School of Medicine 251 E. Huron Street Feinberg Pavilion, Suite 8-336 Chicago, IL 60611	Critical Care Medicine (AN)	William T. Peruzzi, MD	(312)926-2537 (312)926-1700
[0451621068] University of Chicago Program University of Chicago 5841 S. Maryland Avenue, MC 4028 Chicago, IL 60637-0254	Critical Care Medicine (AN)	Michael O'Connor, MD	(773)702-6842 (773)834-0063
[0452421063] Baystate Medical Center Program Baystate Medical Center 759 Chestnut Street Springfield, MA 01199	Critical Care Medicine (AN)	Thomas L. Higgins, MD	(413)794-4326 (413)794-5349
[0452431069] Brigham and Women's Hospital Program Department of Anesthesiology, Perioperative and Pain Medicine Brigham and Women's Hospital 75 Francis Street Boston, MA 02115	Critical Care Medicine (AN)	Nicholas Sadovnikoff, MD	(617)732-8280 (617)264-5230
[0452411001] Beth Israel Deaconess Medical Center Program Beth Israel Deaconess Medical Center 330 Brookline Avenue Boston, MA 02215	Critical Care Medicine (AN)	Alan Lisbon, MD	(617)667-5298 (617)677-5013
[0452431015] Massachusetts General Hospital Program Massachusetts General Hospital 32 Fruit Street Boston, MA 02114	Critical Care Medicine (AN)	William E. Hurford, MD	(617)726-2859 (617)724-8511
[0452431069] Brigham and Women's Hospital Program Brigham and Women's Hospital 75 Francis Street	Critical Care Medicine (AN)	Nicholas Sadovnikoff, MD	(617)732-8280 (617)264-5230

Boston, MA 02115			
[0452431017] University of Massachusetts Program University of Massachusetts Medical School 55 Lake Avenue, North Worcester, MA 01655-1595	Critical Care Medicine (AN)	Stephen O. Heard, MD	(508)856-5581 (508)856-4060
[0452321034] Johns Hopkins University Program Johns Hopkins Hospital Meyer 291 600 North Wolfe Street Baltimore, MD 21287-7294	Critical Care Medicine (AN)	Todd Dorman, MD	(410)955-9080 (410)955-8978
[0452321029] University of Maryland Program University of Maryland Medical Center 22 South Greene Street Baltimore, MD 21201-1595	Critical Care Medicine (AN)	Brenda Fahy, MD	(410)328-6120 (410)328-5531
[0452521060] University of Michigan Program University of Michigan Hospitals 1500 East Medical Center Drive 1H247 UH, Box 0048 Ann Arbor, MI 48109-0048	Critical Care Medicine (AN)	Peter Lee, MD, MPH	(734)936-4280 (734)936-9091
[0452531019] Wayne State University/Detroit Medical Center (Sinai Hospital) Program Detroit Receiving Hospital Department of Anesthesiology, 2-T Annex 4201 St. Antoine Detroit, MI 48201	Critical Care Medicine (AN)	H. Michael Marsh, MD	(313)745-4300
[0452621024] Mayo Graduate School of Medicine (Rochester) Program Mayo Graduate School of Medicine Siebens 5th Floor 200 First Street, SW Rochester, MN 55905	Critical Care Medicine (AN)	Bhargavi Gali, MD	(507)284-4331 (507)284-0999
[0452621061] University of Minnesota Program University of Minnesota MMC 294 420 Delaware Street, SE Minneapolis, MN 55455	Critical Care Medicine (AN)	Ian Hasinoff, MD	(612)624-9990 (612)626-2363
[0452821056] Washington University/B-JH/SLCH Consortium Program Washington University Medical Center Campus Box 8054	Critical Care Medicine (AN)	Walter A. Boyle, MD	(314)362-8543 (314)747-1710

600 S. Euclid Avenue St Louis, MO 63110			
[0453621052] Duke University Program Duke University Medical Center Box 3094 Durham, NC 27710	Critical Care Medicine (AN)	Christopher C. Young, MD	(919)681-4488 (919)681-7893
[0453621023] Wake Forest University School of Medicine Program Wake Forest University School of Medicine Department of Anesthesiology Medical Center Boulevard Winston-Salem, NC 27157-1009	Critical Care Medicine (AN)	Peter C. Brath, MD	(336)716-4498 (336)716-8190
[0453221030] Dartmouth-Hitchcock Medical Center Program Dartmouth-Hitchcock Medical Center One Medical Center Drive Lebanon, NH 03756-0001	Critical Care Medicine (AN)	Athos J. Rassias, MD	(603)650-4642 (603)650-0614
[0453413065] University of New Mexico Program University of New Mexico 2701 Frontier NE, Suite 110 Albuquerque, NM 87131-5216	Critical Care Medicine (AN)	Nivine Doran, MD	(505)272-2734 (505)272-1300
[0453521020] Mount Sinai School of Medicine Program Mount Sinai Hospital Box 1264 One Gustave L Levy Place New York, NY 10029-6574	Critical Care Medicine (AN)	Andrew B. Leibowitz, MD	(212)241-8867 (212)860-3669
[0453511007] New York Presbyterian Hospital (Columbia Campus) Program New York and Presbyterian Hospital (Columbia Campus) 630 West 168th Street New York, NY 10032	Critical Care Medicine (AN)	Robert N. Sladen, MD	(212)305-8633 (212)305-8287
[0453521016] New York University School of Medical Program New York University Medical Center 550 First Avenue New York, NY 10016	Critical Care Medicine (AN)	Brian S. Kaufman, MD	(212)263-5072 (212)263-7254
[0453511054] SUNY Health Science Center at Brooklyn Program SUNY Health Science Center at Brooklyn 450 Clarkson Avenue, Box 6 Brooklyn, NY 11203-2098	Critical Care Medicine (AN)	Jean Charchaflieh, MD	(718)270-3290 (718)270-3133

[0453531053] SUNY Upstate Medical University Program SUNY Health Science Center at Syracuse 750 East Adams Street Syracuse, NY 13210	Critical Care Medicine (AN)	Carlos J. Lopez, MD	(315)464-4890 (315)464-4905
[0453511022] University of Rochester Program University of Rochester Medical Center Box 604 601 Elmwood Avenue Rochester, NY 14642	Critical Care Medicine (AN)	Peter J. Papadakos, MD	(585)273-4750 (585)244-7271
[0453821031] Cleveland Clinic Foundation Program Cleveland Clinic Foundation-G68 9500 Euclid Avenue Cleveland, OH 44195	Critical Care Medicine (AN)	Shahpour Esfandiari, MD	(216)444-6193 (216)444-7360
[0453821012] University Hospitals of Cleveland/Case Western Reserve University Program University Hospitals of Cleveland 11100 Euclid Avenue, LKSD 2514 Cleveland, OH 44106-5007	Critical Care Medicine (AN)	Joel B. Zivot, MD	(216)844-7333 (216)844-3781
[0454121005] University of Pennsylvania Program Hospital of the University of Pennsylvania 775 Dulles Building 3400 Spruce Street Philadelphia, PA 19104	Critical Care Medicine (AN)	Clifford S. Deutschman, MD	(215)662-3751
[0454121028] University Health Center of Pittsburgh Program University Health Center of Pittsburgh Critical Care Medicine 655 Scaife Hall 3550 Terrace Street Pittsburgh, PA 15261	Critical Care Medicine (AN)	Nicholas Bircher, MD	(412)647-3135 (412)647-8060
[0454121038] Penn State University/Milton S. Hershey Medical Center Program Milton S. Hershey Medical Center P.O. Box 850 Hershey, PA 17033	Critical Care Medicine (AN)	John K. Stene, MD, PhD	(717)531-8434 (717)531-4110
[0454721057] Vanderbilt University Program Vanderbilt University Medical Center 504 Oxford House 1313 21st Avenue, South	Critical Care Medicine (AN)	Kenneth Smithson, DO, PhD	(615)343-6268 (615)343-6272

Nashville, TN 37232-4125			
[0454821032] University of Texas at Houston Program Hermann Hospital 6431 Fannin, 5.020 MSB Houston, TX 77030	Critical Care Medicine (AN)	Clifford L. Parmley, MD	(713)792-5219 (713)745-1869
[0454821033] San Antonio Uniformed Services Health Education Consortium (WHMC) Program Wilford Hall Medical Center 2200 Bergquist Drive, Suite 1 Lackland AFB, TX 78236-5300	Critical Care Medicine (AN)	Steven G. Venticinque, MD	(210)292-7956 (210)292-7986
[0454821048] University of Texas Medical Branch Hospitals Program University of Texas Medical Branch 301 University Boulevard Galveston, TX 77555-0591	Critical Care Medicine (AN)	Mali Mathru, MD	(409)747-5781 (409)747-4314
[0455111027] University of Virginia Program University of Virginia Health System P.O. Box 800710 Charlottesville, VA 22908-0710	Critical Care Medicine (AN)	Stuart M. Lowson, MD	(434)924-2283 (434)982-0019
[0455521066] West Virginia University Program West Virginia University 3618 Health Sciences Center P.O. Box 9134 Morgantown, WV 26506-9134	Critical Care Medicine (AN)	Elizabeth Sinz, MD	(304)293-5411 (304)293-7607
[0455621008] University of Wisconsin Program University of Wisconsin Clinical Science Center B6/319 CSC 600 Highland Avenue Madison, WI 53792	Critical Care Medicine (AN)	Jonathan T. Ketzler, MD	(608)263-8114 (608)263-0575
[0455621025] Medical College of Wisconsin Program Froedtert Memorial Lutheran Hospital 9200 W. Wisconsin Avenue Milwaukee, WI 53226	Critical Care Medicine (AN)	Mislav Tonkovic-Capin, MD	(414)805-2715 (414)259-1522

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EXHIBIT R

House
Legislative
Analysis
Section

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MEDICAL MALPRACTICE LIABILITY

Senate Bill 270 (Substitute H-1)
Sponsor: Senator Dan L. DeGrow

House Bill 4033 (Substitute H-3)
Sponsor: Rep. David M. Gubow

House Bill 4403 (Substitute H-1)
Sponsor: Rep. Lynn Owen

House Bill 4404 (Substitute H-1)
Sponsor: Rep. Lynn Owen

Second Analysis (4-20-93)
Senate Committee (SB 270): Judiciary
House Committee (HB 4033): Mental Health
House Committee (other bills): Judiciary

THE APPARENT PROBLEM:

In 1986, the legislature enacted a series of reforms aimed at growing concerns about the effect of the medical liability system on the availability and affordability of health care in Michigan. Reforms that specifically addressed medical liability included limiting awards for noneconomic loss (that is, pain and suffering) to $225,000 (with exceptions), specifying qualifications for expert witnesses, constricting the statute of limitations for bringing a medical malpractice lawsuit, providing for the dismissal of a defendant upon an affidavit of noninvolvement, requiring mediation, and requiring each party either to provide security for costs or to file an affidavit of meritorious claim or defense.

Opinion is widespread in the medical community and elsewhere that these reforms have proved inadequate. Providers of medical care and malpractice insurance cite numerous statistics to support their case. For both doctors and hospitals, medical malpractice insurance costs much more in Michigan than elsewhere; Detroit area hospitals pay the highest liability rates in the country, and even smaller, outstate hospitals pay more than some urban hospitals elsewhere. The average liability cost per bed is $1,400 nationally, $4,600 for the state as a whole, and $6,900 in Detroit, while the $2,800 per bed average for rural Michigan is higher than figures cited for Chicago and Cleveland. A 1990 report of the U.S. Government Accounting Office (GAO) confirms that while rates declined in the nation and adjacent states since about 1988, Michigan rates have continued to increase, although at a slower rate since 1986.

Reports are that only 37 cents of each dollar spent on medical liability premiums goes to victims of malpractice, while roughly half of the money paid in premiums goes to legal fees (plaintiff and defense combined) and court costs. Payouts per claim are increasing; one hospital insurer reports a 173 percent increase--from $51,000 to $139,000--in its average payout per claim between 1986 and 1990. Lawsuits, too, are on the rise, threatening to widen the gap between Michigan and other states; nationally, about a half-dozen lawsuits are filed annually for every 100 physicians, but the figure for Michigan is closer to 20 lawsuits per 100 physicians.

Using survey results and anecdotal evidence, critics of the current system maintain that litigiousness and the high cost of insurance in Michigan drive out physicians, either literally out of the state, or out of practice through early retirement. Many other physicians choose to remain in practice, but eliminate costly elements such as obstetrics that carry a comparatively high risk for lawsuits (for example, obstetrical coverage in Detroit costs $134,000 annually for $1 million per occurrence/$3 million aggregate coverage; for $100,000/$300,000

coverage, the annual cost is $63,000). The medical liability climate thus is held at least partly responsible for problems that people in urban centers and rural areas have in obtaining medical care, and responsible for increasing health care costs by forcing physicians to practice "defensive medicine."

One thing that carries the potential to reduce the time and expense of malpractice lawsuits is the use of binding arbitration. However, existing arbitration provisions, which date to 1975, are little used; lack of participation has been attributed to patients' distrust of the current makeup of arbitration panels (which must have a physician as one of the three members), physician reluctance to serve on panels, the unwieldy process, and a lack of incentives to participate.

To alleviate problems with the state's medical liability system and address widespread dissatisfaction with it, further reforms have been proposed.

THE CONTENT OF THE BILLS:

Senate Bill 270 would amend the Revised Judicature Act (MCL 600.1483 et al.) to do the following with regard to medical malpractice actions: revise limits on noneconomic damages and link them to compliance with proposed financial responsibility requirements, limit attorneys' contingency fees, require expert witnesses to be of the same board-certified specialty or health profession as the defendant, bar a plaintiff from receiving payment for the loss of an opportunity to survive, require a plaintiff to notify a defendant 182 days before filing a suit, provide for the waiver of the physician-patient privilege when a malpractice suit is commenced, enact new provisions on voluntary binding arbitration, generally constrict the statute of limitations on suing for injuries done to minors, and eliminate the tolling (suspension) of the statute of limitations when a foreign object was left in the body.

The bill is tie-barred to House Bills 4033, 4403, 4404, and the "physician discipline" package (House Bills 4076, 4295, and companion bills). Generally speaking, provisions that are procedural in nature (such as those dealing with expert witnesses, arbitration, and the 182-day notice requirement) would apply to cases filed on or after October 1, 1993, while substantive provisions (such as those dealing with noneconomic loss limits and statutes of limitations) would apply to causes of action arising on or after October 1, 1993.

A more detailed explanation follows.

Noneconomic losses. The bill would replace the current $225,000 limit on noneconomic losses (which statutory adjustments for inflation have increased to a reported $280,000) and the exceptions to it with a two-tier limit. Generally, payment for noneconomic losses could not exceed $500,000. However, the limit would be $1 million if there had been a death, if there were a permanent disability due to an injury to the brain or spinal cord, if damage to a reproductive organ left a person unable to procreate, or if a medical record had been illegally destroyed or falsified. The award caps would be halved for a defendant who was in compliance with the financial responsibility requirements proposed by House Bill 4404. Caps would be annually adjusted for inflation.

Contingency fees. An attorney's contingency fee would be limited to 15 percent of the amount recovered if the claim was settled before mediation or arbitration, 25 percent if settled after mediation or arbitration but before trial, and 33-1/3 percent if the claim went to trial. (Court rules limit contingency fees to 33-1/3 percent.) The bill would prescribe the manner of computing the fee, require a contingency fee agreement to be in writing, and require an attorney to make certain disclosures regarding fees. An attorney whose contingency fee agreement provided for a contingency fee in excess of that allowed could not collect more than what would be received under his or her usual hourly rate of compensation, up to the amount provided by the applicable contingency fee limit.

Expert witnesses. At present, if the defendant physician or dentist is a specialist, an expert witness must be of the same or related specialty and at the time devoting a substantial portion of his or her professional time to either active clinical practice or medical or dental school instruction. Under the bill, each expert witness (not just those in cases involving specialists) would have to have spent a substantial portion of the preceding year in active clinical practice in the same health profession as the defendant or in the instruction of students. If a defendant was board-certified, the witness would have to be, and if the defendant was a general

practitioner, the witness would have to either be a general practitioner or instructing students.

Neither the tax returns nor the personal diary or calendar of an expert witness could be sought or used by counsel to determine whether an expert witness was qualified, and counsel would be forbidden from interviewing the witness's family members concerning the amount of time the witness spent engaged in his or her health profession.

Lost opportunity to survive. A plaintiff would be barred from recovering for a lost opportunity to survive. (This would override the 1990 decision of the Michigan Supreme Court in Falcon v. Memorial Hospital, 436 Mich. 443. In that case, the court held that in medical malpractice actions, loss of an opportunity to survive is compensable in proportion to the extent of the lost opportunity, even though the opportunity was less than fifty percent and it was not probable that an unfavorable result would or could have been avoided. Under this decision, the plaintiff must establish that the defendant more probably than not reduced the opportunity of avoiding harm.)

Advance notice of suit. For the stated purposes of promoting settlement without the need for formal litigation, reducing the cost of medical malpractice litigation, and providing compensation for meritorious medical malpractice claims that would otherwise be precluded from recovery because of litigation costs, the bill would require a plaintiff planning to file suit to notify a defendant at least 182 days before commencing court action. The notice could be filed later if a statute of limitations was about to apply. Meeting the 182-day requirement for one defendant would cover meeting it for any future defendants added to the suit. The notice would have to contain certain minimum information about the case and its basis.

The claimant and the defendant would have to give each other access to each other's medical records within 91 days after the notice. A defendant's failure to allow timely access to records would be penalized under provisions regarding affidavits of merit and interest on judgments (see below). Within 126 days after the notice, the defendant would have to furnish the claimant with a written response with certain information about the defense; failure to provide the information on time would entitle the claimant to file suit immediately.

Affidavits of merit. Existing law requires plaintiffs and defendants either to post a $2,000 bond or other financial security for payment of costs, or to file an affidavit of meritorious claim or defense. The bill would delete provisions allowing security for costs to be filed in lieu of an affidavit. Affidavits would have to contain information on the basis and allegations of the case, as prescribed by the bill (this information would parallel that to be exchanged under the 182-day notice provisions). If the defendant failed to allow access to medical records as required by the 182-day notice provisions, a plaintiff's affidavit could be filed 91 days after the complaint.

Professional privilege. Someone claiming malpractice would be considered to have waived the physician-patient privilege or similar privilege with respect to a person or entity who was involved, whether or not that person was a party to the claim or action. A defendant could communicate with other health facilities or professionals to obtain relevant information and prepare a defense; disclosure of that information to the defendant would not constitute a violation of the physician-patient privilege.

Arbitration. The bill would repeal Chapter 50a of the act, which provides for arbitration of medical malpractice lawsuits, and replace it with provisions for voluntary binding arbitration that would apply to cases where damages claimed amounted to $75,000 or less, including interest and costs. The bill's arbitration procedures would be available during the 182-day notice period (that is, after notice was given but before a case was filed). Unlike current law, which calls for an arbitration panel consisting of a doctor, a lawyer, and someone who is neither, under the bill the parties would agree to a process for the selection of a single arbitrator. The arbitration agreement would also apportion the costs of the arbitration and contain waivers of the right to trial and appeal; defendants would waive the question of liability. The parties could agree to a total amount of damages greater than $75,000.

There would be no live testimony, and court rules on discovery would not apply, although certain information would have to be exchanged upon request under deadlines established by the arbitrator. The arbitrator could issue the decision with or without holding a formal hearing, although he or she would have to conduct at least one telephone conference call or meeting with the

parties. If there was a hearing, it would have to be limited to presentation of oral arguments. The arbitrator would issue a written decision stating the factual basis for it and the amount of any award. There would be no right to appeal the award.

Settlements. If a case was settled (with or without court supervision), the parties would have to file a copy of the settlement agreement with the appropriate bureau of the Department of Commerce. The information would be confidential except for use by the department in an investigation; it would not be subject to the Freedom of Information Act.

Mediation. Current law provides for mediation of medical malpractice suits. Under the bill, if a defendant rejected a mediation panel's evaluation, but the plaintiff did not, and the case went to trial, the defendant's insurer would be liable for the plaintiff's costs unless the verdict was more favorable to the defendant than the mediation evaluation.

Statute of limitations--general. Generally, a medical malpractice action must be commenced within two years after the injury was caused, or six months after it was or should have been discovered, whichever was later; however, in no event may it be commenced more than six years after the injury was caused. However, for certain injuries, this six-year statute of repose does not apply; the bill would eliminate an exception for situations where a foreign object was wrongfully left in the patient's body, and limit an exception for reproductive injuries to those where there was a loss of the ability to procreate in someone under 35 years old. An exception for fraudulent conduct of a health care provider would be retained. Giving 182-day notice as required by the bill would toll (suspend the running of) the statute of limitations.

Statute of limitations--minors. The running of the statute of limitations is suspended until someone reaches age 13. For injuries to a child that occur before age thirteen, action must be commenced by the time the child reaches age 15; after age 13 the regular medical malpractice statute of limitations applies. Under the bill, the running of the statute of limitations would be suspended until a child reached age 10, and an action for a child under that age would have to be commenced before the child's twelfth birthday, or within the regular medical malpractice period of limitations, whichever was later (the six-year statute of repose would not apply).

However, if an injury to the reproductive system of someone under age 13 was claimed, the claim would have to be brought before his or her fifteenth birthday or before the regular medical malpractice statute of limitations would apply, whichever was later (the six-year statute of repose would not apply).

Interest on judgments. The law now provides for the calculation and payment of interest on judgments. Under the bill, if a medical malpractice defendant failed to allow access to records as required by the 182-day notice provisions, the court would order that interest be calculated from the date notice was given to the date of satisfaction of the judgment. The injured party, and not his or her attorney, would receive the interest accruing on the portion of a judgment represented by the attorney's fee.

House Bill 4403 would amend the Insurance Code (MCL 500.2204) to require an commercial liability insurer to pay the plaintiff's attorney fees and court costs when an insured defendant had rejected a mediation evaluation under the Revised Judicature Act, the plaintiff had not rejected it, and the case went to trial. However, the payment requirement would not apply if the verdict was more favorable to the defendant than the mediation evaluation. The bill could not take effect unless Senate Bill 270 was enacted.

House Bill 4404 would amend the Public Health Code (MCL 333.16280 and 333.21517) to require each physician, dentist, psychologist, chiropractor, and podiatrist to maintain financial responsibility for medical malpractice actions. The financial responsibility would have to be one of the following: a $200,000 surety bond or irrevocable letter of credit; an escrow account containing at least $200,000 in cash or unencumbered securities; or professional liability insurance coverage with limits of at least $200,000 per claim and $600,000 in the aggregate.

Someone licensed on or before October 1, 1993 would have to file proof of financial responsibility with his or her licensing board by January 1, 1994. Others would have to file proof within 90 days after the issuance of a license. After the initial filing, proof would have to be filed annually.

Financial responsibility requirements would not apply to someone with a hospital affiliation, if the hospital provided the equivalent amount of financial responsibility. However, if the person practiced outside of the hospital, he or she would have to maintain financial responsibility for that portion of his or her practice performed outside the hospital. Financial responsibility requirements would not apply to someone whose practice outside of a hospital consisted of at least 25 percent uninsured and Medicaid patients, based on the total number of patients treated annually by the person. Proof of such a practice would have to be filed with the person's board.

A hospital would be prohibited from granting privileges to a physician unless financial responsibility requirements were met. Compliance with the bill would not be a condition of licensure for a physician or other person required to maintain financial responsibility.

The bill could not take effect unless Senate Bill 270 was enacted.

House Bill 4033 would amend the Mental Health Code to forbid a licensee under the code (a mental hospital, psychiatric hospital, or psychiatric unit) from granting privileges to physician who was not in compliance with the financial responsiblity requirements of House Bill 4404, unless the licensee covered the physician as allowed by House Bill 4404. The bill could not take effect unless Senate Bill 270 was enacted.

HOUSE COMMITTEE ACTION:

The House Judiciary Committee adopted a substitute for Senate Bill 270 that differed from the Senate-passed bill in proposing new provisions on arbititration, and linking medical malpractice reform to requirements for financial responsibility. The substitute's provisions on contingency fees, noneconomic losses, expert witnesses, and the statute of limitations also differed from those in the Senate-passed version.

FISCAL IMPLICATIONS:

Fiscal information is not available at present.

ARGUMENTS:

For:

The bills would go far to discourage unjustified medical malpractice lawsuits and reduce the costs of the medical malpractice liability system, thus helping to contain spiraling health care costs, stem the flight of physicians out of Michigan, and assure the citizens of this state access to affordable health care. Stricter limits on pain and suffering awards, limits on contingency fees, early notice requirements, and new arbitration provisions would reduce litigation costs by encouraging arbitration and early settlement and curbing excessive awards.

New limits on pain and suffering awards and the medical malpractice statute of limitations would further help to reduce insurance costs by addressing the uncertainties and long period of exposure in this highly volatile area of insurance. Without such measures and controls on the costs of litigation, there is little to be done to reduce premiums, for neither they nor profits are inflated: the major malpractice insurers are customer-owned (that is owned by physicians or hospitals), and the insurance bureau reports a healthy degree of competition in the marketplace.

Victims of medical malpractice would not be ignored, however: requirements for physicians to maintain financial responsibility, provisions on payment of judgment interest, and incentives to arbitrate small suits that might otherwise go begging for legal representation all would help to put money in injured patients' pockets. Links to the physician discipline package would recognize the need to also protect patients by reducing the incidence of malpractice. And, eventually, the bills would help patients by holding back health care costs, and not only through effects on premiums; far greater savings are likely through easing physicians' litigation fears, thus reducing the need to practice "defensive medicine" which drives up the cost of health care through the use of high technology and second opinions.

The bills offer a balanced compromise that should streamline the system to the ultimate benefit of both patients and health care providers.

Against:

Many dispute whether there really is any sort of malpractice "crisis" that demands resolution, especially a resolution that restricts legal recourse for victims of malpractice. If Michigan has more than its share of malpractice lawsuits, it is because Michigan ranks low in its effectiveness in getting bad doctors out of business, and because insufficient attention has been devoted to risk management in hospitals, where the vast majority of malpractice claims arise. If insurance costs too much, it is because insurers are charging too much; profits are up in recent years, but premiums continue to rise. More carriers are writing malpractice insurance in Michigan, and availability problems have decreased.

The numbers of physicians are up, not down, thus countering assertions that Michigan's malpractice climate has led to problems in obtaining care. Moreover, it is unreasonable to hold the medical malpractice system responsible for the lack of health care for residents of poor urban and rural areas of Michigan; recruiting doctors to such places is a problem across the country, and has long been so.

If rising costs of health care are a real concern, then attacking the medical liability system would have little effect: insurance premiums represent only one or two percent of total health care costs, and "defensive medicine" habits are unlikely to be affected (nor should they, say some, as the caution

argued to meet the exception for permanent disability.

Contingency fee provisions also are inadequate: without firm limits on attorneys' financial incentives to seek windfall awards in marginal cases, case filings are unlikely to decline. Worse, the proposed sliding scale would give attorneys an incentive to push for trial by giving them a bigger take than if they settled out of court or accepted arbitration.

Finally, Senate Bill 270 would do nothing to rid the system of professional witnesses. By allowing expert witnesses to qualify if they spend a "substantial portion" of their time in the necessary fields, the bill would continue to allow justice to be subverted by traveling "guns for hire."

Against:

Limits on contingency fees raise a number of constitutional issues. Being a matter of practice and procedure, contingency fees are properly within the constitutionally-determined purview of the supreme court, and are at present set by supreme court rule. An attempt to regulate contingency fees in statute would conflict with the court's constitutional rule-making authority and the doctrine of separation of powers. Statutory limits on plaintiffs' attorney fees may also violate constitutional provisions for equal protection, if defendants' fees are not also regulated. Finally, by inserting itself into a matter that is between attorney and client, Senate Bill 270 may intrude on the right to contract.

The Michigan Trial Lawyers Association does not support the package. (3-30-93)

The Advocacy Organization for Patients and Providers does not believe the package will resolve the problem, in part because it is not linked to insurance reform. (3-30-93)

Physicians Insurance Company of Michigan (PICOM) opposes the package, but could support it with amendments. (3-30-93)

The Michigan Medical Liability Reform Coalition opposes the bills. (3-30-93) Organizations in the 75-member coalition include the following:

Greater Detroit Chamber of Commerce
Michigan Association for Local Public Health
Michigan Association of Osteopathic Physicians and Surgeons
Michigan Dental Association
Michigan Farm Bureau
Michigan Hospital Association
Michigan Hospital Association Mutual Insurance Company
Michigan Insurance Federation
Michigan Manufacturers Association
Michigan Physicians Mutual Liability Company
Michigan State Medical Society
Physicians Insurance Company of Michigan

EXHIBIT S

Senate Fiscal Agency
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SFA BILL ANALYSIS

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Senate Bill 270
Sponsor: Senator Dan L. DeGrow
Senate Committee: Judiciary
House Committee: Judiciary

Date Completed: 8-11-93

PUBLIC ACT 78 of 1993

MASTER FILE

SUMMARY OF SENATE BILL 270 as enrolled:

The bill would amend the Revised Judicature Act (RJA) to implement certain revisions in medical liability determination procedures. The bill would do all of the following:

- **Provide for a cap of $280,000--or $500,000 if certain exceptions applied--on the total amount of noneconomic damages recoverable by all plaintiffs in a medical malpractice action.**
- **Revise the RJA's regulations on the use of an expert witness in a medical malpractice action.**
- **Require a 182-day notice before a medical malpractice action could be commenced; require a response to that notice within 154 days; and require each party to give the other access to related medical records in the party's control.**
- **Require all medical malpractice plaintiffs to file an affidavit of merit, and require all defendants to file an affidavit of meritorious defense.**
- **Permit the binding arbitration of medical malpractice actions involving damages of $75,000 or less, and repeal current provisions on health care arbitration.**
- **Require parties settling a medical malpractice action to file a copy of the settlement agreement with the Department of Commerce.**
- **Revise the statute of limitations (SOL) for certain medical malpractice claims.**
- **Make other provisions pertaining to: burden of proof; waiver of a plaintiff's physician-patient privilege; and interest on judgments.**

Award Cap

Under the RJA, damages for noneconomic loss that result from a medical malpractice claim are limited to $225,000, except in cases involving a death; an injury involving the patient's reproductive system; the loss of a vital bodily function; an intentional tort; and circumstances under which a foreign object was left in a patient's body, a health care provider's fraudulent conduct prevented the discovery of a claim, or a patient's limb or organ was wrongfully removed. ("Noneconomic loss" means "damages or loss due to pain, suffering, inconvenience, physical impairment, physical disfigurement, or other noneconomic loss".)

The bill provides, instead, that the total amount of damages for noneconomic loss recoverable by all plaintiffs, resulting from the negligence of all defendants, could not exceed $280,000. The total amount of noneconomic damages could not exceed $500,000, however, if as the result of the negligence of one or more of the defendants, any of the following exceptions applied as determined by the court:

- The plaintiff was hemiplegic, paraplegic, or quadriplegic resulting in a total permanent functional loss of one or more limbs caused by brain and/or spinal cord injury.
- The plaintiff had permanently impaired cognitive capacity rendering him or her incapable of making independent, responsible life decisions and permanently incapable of independently performing

the activities of normal, daily living.
- There had been permanent loss of or damage to a reproductive organ resulting in the inability to procreate.

The court would be required to reduce an award in excess of either of the proposed limitations to the amount of the appropriate limitation. Neither the court nor counsel for either party could advise the jury of these limitations or any of the law's provisions concerning noneconomic damages.

Under the RJA, the noneconomic loss limit must be "increased" annually by an amount determined by the State Treasurer to reflect the cumulative annual percentage "increase" in the consumer price index (CPI). The bill provides, instead, that the State Treasurer would have to "adjust" the noneconomic loss limit to reflect the "change" in the CPI.

Expert Witnesses

In an action alleging medical malpractice, the RJA prohibits a person from giving expert testimony on the appropriate standard of care, if the defendant is a specialist, unless the expert witness is a "physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry" in Michigan or another state and is a specialist in the same or a related, relevant area as the defendant. An expert witness also must devote, or have devoted at the time of the occurrence in question, a "substantial portion" of his or her professional time to clinical practice or the instruction of students in the same or a related specialty at an accredited medical, osteopathic, or dental school.

The bill, instead, would require that an expert witness be a licensed "health professional" in Michigan or another state. If the party against whom or on whose behalf the witness offered testimony were a specialist, the expert witness would have to specialize in the same specialty as the party. If the party were a board-certified specialist, the expert witness also would have to board-certified in that specialty.

In addition, during the year immediately preceding the date of the occurrence in question, the expert witness would have to have devoted a majority of his or her professional time to either or both of the following:

- The active clinical practice of the same health profession in which the party was licensed and, if the party were a specialist, active clinical practice in that specialty.
- The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same profession in which the party was licensed and, if the party were a specialist, in an accredited health professional school or accredited residency or clinical research program in the same specialty.

If the party against whom or on whose behalf the witness offered testimony were a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence in question, would have to have devoted a majority of his or her professional time to active clinical practice as a general practitioner, and/or to instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party was licensed.

All of the following limitations would apply to discovery conducted by opposing counsel to determine whether an expert witness was qualified:

- Tax returns of the expert would not be discoverable.
- Family members of the expert could not be deposed concerning the amount of time he or she spent engaged in the practice of his or her health profession.
- A personal diary or calendar (one not including listings or records of professional activities) belonging to the expert would not be discoverable.

Notice/Access to Records/Response

Notice. A person could not commence a medical malpractice action against a health professional or health facility, unless he or she gave the professional or facility written notice of the action at least 182 days before filing the action. The notice of intent to file a claim would have to be mailed to the last known professional business address or residential address of the health professional or health facility. Proof of the mailing would constitute prima facie

evidence of compliance with these requirements. If no last known professional business or residential address could be reasonably ascertained, notice could be mailed to the health facility where the care that was the basis for the claim was rendered.

The 182-day notice period would be shortened to 91 days if all of the following conditions existed:

- The claimant had previously filed the 182-day notice against other health professionals or health facilities involved in the claim.
- The 182-day notice period had expired as to the other health professionals or facilities.
- The claimant had filed a complaint and commenced a medical malpractice action against one or more of the other health professionals or health facilities.
- The claimant did not identify, and could not reasonably have identified a health professional or facility to which notice had to be sent as a potential party to the action before filing the complaint.

The notice given to a health professional or facility would have to state at least all of the following:

- The factual basis for the claim.
- The applicable standard of practice or care alleged by the claimant.
- The manner in which it was claimed that the applicable standard was breached.
- The alleged action that should have been taken to achieve compliance with the alleged standard.
- The manner in which it was alleged the breach was the proximate cause of the injury claimed.
- The names of all health professionals and facilities the claimant was notifying in relation to the claim.

After the initial notice was given to a health professional or facility, the tacking or addition of successive 182-day periods would not be allowed, irrespective of how many additional notices were subsequently filed for that claim or the number of health professionals or facilities notified.

Records. Within 56 days after giving notice, the claimant would have to allow the health professional or facility access to all of the medical records related to the claim that were in the claimant's control, and would have to furnish releases for any medical records related to the claim that were not in the claimant's control, but of which he or she had knowledge. Within 56 days after receiving notice, the health professional or facility would have to give the claimant access to all medical records related to the claim that were in the control of the health professional or facility. These provisions would not restrict a health professional or facility receiving notice from communicating with other health professionals or facilities and acquiring medical records as permitted by the bill. These provisions would not restrict a patient's right of access to his or her medical records under any other provision of law.

Response. With 154 days after receiving notice, the health professional or facility against whom the claim was made would have to give the claimant or his or her authorized representative a written response that stated each of the following:

- The factual basis for the defense to the claim.
- The standard of practice or care that the health professional or facility claimed to be applicable to the action and that the professional or facility complied with that standard.
- The manner in which it was claimed that there was compliance with the applicable standard.
- The manner in which the health professional or facility contended that the alleged negligence was not the proximate cause of the claimant's alleged injury or damage.

Commencement of Action. If the claimant did not receive the written response within the 154-day period, he or she could commence an action alleging medical malpractice upon the expiration of that period.

If at any time during the applicable notice period a health professional or facility receiving notice informed the claimant in writing that the professional or facility did not intend to settle the claim within the applicable notice period, the claimant could commence a medical malpractice action against the professional or facility, as long as the claim was not barred by the statute of limitations.

Affidavit of Merit

In a medical malpractice action, the RJA requires that a complaint be accompanied either by security for costs or by an affidavit. The security may take the form of a bond with surety or any other equivalent security approved by the court, including cash in an escrow account, for costs in an amount of $2,000. An affidavit may be filed by the plaintiff or the plaintiff's attorney and must attest that the plaintiff or attorney has obtained a written opinion from a licensed physician, dentist, or other appropriate licensed health care provider that the claim alleged is meritorious.

The bill would delete the provisions pertaining to security for costs and revise the provisions requiring an affidavit. Under the bill, a medical malpractice plaintiff or plaintiff's attorney would have to file with the complaint an affidavit of merit signed by a health professional whom the plaintiff's attorney reasonably believed met the proposed requirements for an expert witness. The affidavit of merit would have to certify that the health professional had reviewed the notice and all medical records supplied to him or her by the plaintiff's attorney concerning the allegations contained in the notice, and state each of the following:

- The applicable standard of practice or care.
- The health professional's opinion that the applicable standard was breached by the health professional or facility receiving the notice.
- The actions that should have been taken or omitted by the health professional or facility in order to have complied with the applicable standard.
- The manner in which the breach of the standard was the proximate cause of the alleged injury.

Upon motion of a party for good cause shown, the court could grant the plaintiff or plaintiff's attorney an additional 28 days in which to file the affidavit.

If the defendant failed to allow access to medical records within the time period set forth above, the affidavit of merit could be filed within 91 days after the complaint was filed (rather than with the complaint).

Affidavit of Meritorious Defense

Currently, the RJA provides that, within 21 days after a plaintiff furnishes security or files an affidavit, the defendant must file an answer to the complaint. Within 91 days after filing an answer, the defendant must furnish security for costs or file an affidavit attesting that the defendant or defendant's attorney has obtained a written opinion from a licensed physician, dentist, or other appropriate licensed health care provider that there is a meritorious defense to the claim.

The bill would delete reference to security for costs and revise the affidavit requirements. Under the bill, the defendant would have to file an affidavit of meritorious defense signed by a health professional whom the defendant's attorney reasonably believed met the proposed requirements for an expert witness. The affidavit would have to certify that the health professional had reviewed the complaint and all medical records supplied to him or her by the defendant's attorney concerning the allegations in the complaint, and state each of the following:

- The factual basis for each defense to the claims made against the defendant in the complaint.
- The standard of practice or care that the defendant health professional or facility claimed to be applicable to the action and that the health professional or facility complied with that standard.
- The manner in which it was claimed by the defendant that there was compliance with the applicable standard.
- The manner in which the defendant contended that the alleged injury or damage was not related to the care and treatment rendered.

The affidavit of meritorious defense would have to be filed within 91 days after the plaintiff's affidavit of merit was filed. If the plaintiff failed to allow access to medical records as required, however, the affidavit of meritorious defense could be filed within 91 days after an answer to the complaint was filed.

Binding Arbitration

At any time after notice of intent to file a claim was given, if the total amount of damages claimed were $75,000 or less, including interest

and costs, all claimants and all health professionals or health facilities notified could agree in writing to submit the claim to binding arbitration. An arbitration agreement entered into under these provisions would have to contain at least all of the following provisions:

- A process for the selection of an arbitrator.
- An agreement to apportion the costs of the arbitration.
- A waiver of the right to trial.
- A waiver of the right to appeal.

The claimants giving notice and the health professionals or facilities receiving notice could agree in writing to a total amount of damages greater than the limit set forth above.

Arbitration conducted under these provisions would be binding as to all parties who had entered into the written agreement. Arbitration would have to be summary in nature, the proceeding would have to be conducted by a single arbitrator chosen by agreement of all parties to the claim, and there could be no live testimony of parties or witnesses. The Michigan Court Rules pertaining to discovery would not apply, although all of the following information would have to be disclosed and exchanged between the parties upon a party's written request:

- All relevant medical records or medical authorizations sufficient to enable the procurement of all relevant medical records.
- An expert witness report or statement, but only if the party procuring the report or statement intended to or did furnish it to the arbitrator for consideration.
- Relevant published works, medical texts, and scientific and medical literature.
- A concise written summary prepared by a party or the party's representative setting forth the party's factual and legal position on the damages claimed.
- Other information considered by the party making the request to be relevant to the claim or a defense to the claim.

The arbitrator would have to conduct one or more prehearing telephone conference calls or meetings with the parties or their attorneys, for the purpose of establishing the orderly request for and exchange of information described above, and any other advance disclosure of information considered reasonable and necessary in the arbitrator's sole discretion. The arbitrator would have to set deadlines for the exchange or advance disclosure of information.

The arbitrator could issue his or her decision without holding a formal hearing based solely upon his or her review of the materials furnished by the parties. In his or her sole discretion and whether or not requested to do so by a party, the arbitrator could hold a hearing. A hearing would be limited solely to the presentation of oral arguments, subject to time limitations set by the arbitrator.

A written agreement to submit the claim to binding arbitration would be binding on each party signing the agreement and on his or her representatives, insurers, and heirs. An arbitration agreement signed on behalf of a minor or a person who was otherwise incompetent would be enforceable and would not be subject to disaffirmance or disavowal, if the minor or incompetent person were represented by an attorney at the time the agreement was executed.

The arbitrator would have to issue a written decision that stated at a minimum the factual basis for the decision and the dollar amount of the award. The arbitrator could not include costs, interest, or attorney fees in an award. A party could submit an arbitrator's award to a court of competent jurisdiction for entry of judgment on and enforcement of the award. An arbitration award could not be appealed.

Statute of Limitations

The RJA provides that an action involving a medical malpractice claim may be commenced at any time within the applicable period prescribed by the Act, or within six months after the plaintiff discovers, or should have discovered, the claim's existence, whichever is later. No claim, however, may be commenced later than six years after the date of the act or omission that is the basis for the claim, unless discovery of the claim were prevented by a health care provider's fraudulent conduct, a foreign object were left in the patient's body, or the injury involved the reproductive system. The bill would revise those exceptions by allowing a claim to be commenced later than six years after the date of the act or omission only if 1) there had been permanent

loss of or damage to a reproductive organ resulting in the inability to procreate; or 2) discovery of the claim's existence were prevented by the fraudulent conduct of the health care professional against whom the claim was made, the health facility against which the claim was made, or a named employee or agent of the health professional or facility.

Under the RJA, if a person is under 18 years old at the time he or she is first entitled to bring an action, the SOL applicable to his or her claim is suspended until one year after the disability of infancy is removed. The RJA specifies, however, that if a medical malpractice claim accrues to a person who is 13 years old or younger, an action based on the claim must be commenced on or before his or her 15th birthday. If the person is over 13 when the claim accrues, he or she is subject to the usual medical malpractice SOL. The bill provides, instead, that if a claim alleging medical malpractice accrued to a person who had not reached his or her eighth birthday, an action based on the claim would have to be commenced on or before his or her 10th birthday, or within the usual medical malpractice SOL, whichever was later. A person who was eight or older at the time a medical malpractice claim accrued would be subject to the limitation period otherwise applicable to that type of claim.

If, however, a person had not reached his or her 13th birthday at the time a medical malpractice claim accrued to the person, and the claim involved an injury to the person's reproductive system, an action based on the claim could not be brought unless it were commenced on or before the person's 15th birthday or within the period of limitations generally applicable to medical malpractice claims, whichever was later. If a person had reached his or her 13th birthday at the time a medical malpractice claim accrued, and the claim involved an injury to the person's reproductive system, the generally applicable SOL would apply.

The bill provides that the statute of limitations or repose would be tolled if, during the applicable notice period under the section requiring a notice of intent to file a claim, a claim would be barred by the statute of limitation or repose, for not longer than a number of days equal to the number of days in the applicable notice period after the date notice was given in compliance with that section.

Other Provisions

Settlement Agreement. If a plaintiff in a medical malpractice action entered into a settlement agreement with a defendant concerning the action, whether or not the settlement was entered into under court supervision, and the defendant were licensed or registered under Article 15 of the Public Health Code, the plaintiff's attorney and the defendant's attorney, or, if the parties were not represented by attorneys, the plaintiff and the defendant, would be required jointly to file a complete written copy of the settlement agreement with the bureau within the Department of Commerce responsible for health occupations licensure, registration, and discipline, within 30 days after entering into the settlement agreement.

This information would be confidential except for use by the Department in an investigation, and would not be subject to disclosure under the Freedom of Information Act.

Burden of Proof. In a medical malpractice action, the plaintiff would have the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants.

Loss of Opportunity. The plaintiff could not recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity were greater than 50%.

Waiver of Physician-Patient Privilege. A person who gave notice of a medical malpractice claim or commenced a medical malpractice action would waive, for purposes of that claim or action, his or her physician-patient privilege with respect both to persons and entities involved in the acts, transactions, events, or occurrences that were the basis for the claim or action, and to those who provided care or treatment to the claimant or plaintiff in the claim or action for that condition or a condition related to the claim or action either before or after those acts, transactions, events, or occurrences, regardless of whether the person were a party to the action.

In order to obtain all information relevant to the subject matter of the claim or to prepare a defense, a person or entity who had received

notice of a medical malpractice claim or had been named as a defendant in a medical malpractice action, or that person's or entity's attorney or authorized representative, could communicate with a licensed health care professional or facility or a facility's employees. A person who disclosed information under this provision to a person or entity who had received notice of a medical malpractice claim or been named as a defendant in a medical malpractice action, or to that person's attorney or authorized representative, would not be in violation of a physician-patient privilege or any other similar duty or obligation created by law and owed to the claimant or plaintiff.

Interest. Interest on a money judgment would have to be calculated on the entire amount of the judgment, including attorney fees and other costs. The amount of interest attributable to that part of the judgment from which attorney fees were paid, however, would have to be retained by the plaintiff, and not paid to the plaintiff's attorney.

The RJA generally requires that a court order interest to be calculated from the date a complaint is filed to the date the judgment is satisfied. Under the bill, however, if the defendant in a medical malpractice action failed to allow access to medical records as required by the bill, the court would have to order that interest be calculated from the date that notice of intent to file a claim was given in compliance with the section requiring notice, to the date the judgment was satisfied. Further, if the plaintiff in medical malpractice action failed to allow access to medical records as required, the court would have to order that interest be calculated from 182 days after the date the complaint was filed to the date the judgment was satisfied.

Repeal. The bill would repeal provisions that permit a health care recipient to execute an agreement to arbitrate a dispute arising out of health care or treatment rendered by a health care provider or hospital, and that govern those arbitration proceedings (MCL 600.5040-600.5065).

Effective Date

The bill provides that it would take effect October 1, 1993.

Sections pertaining to noneconomic damages, burden of proof, recovery for loss of an opportunity, and the statute of limitations, as amended by the bill, would not apply to causes of action arising before October 1, 1993. Sections pertaining to expert testimony, affidavit of merit, affidavit of meritorious defense, interest, reduction of an award, and advising a jury of noneconomic damages limitations, as amended by the bill, would not apply to cases filed before that date.

Sections pertaining to waiver of the physician-patient privilege, notice of intent to file a claim, binding arbitration, and settlement agreements, as added or amended by the bill, would apply to causes of action arising on or after October 1, 1993, or cases filed on or after that date.

Tie-Bar

The bill is tie-barred to House Bills 4295, 4076, 4077, 4078, 4289, 4290, and 4292 (Public Acts 79 through 86 of 1993), which pertain to health professionals' disciplinary process.

MCL 600.1483 et al.

Legislative Analyst: S. Margules

FISCAL IMPACT

The bill's provisions that would limit malpractice suit award amounts and the number of malpractice suits filed would have some fiscal impact on the following State and local agencies that employ physicians and other health care professionals: the Department of Mental Health, Department of Corrections, the Veterans' Facilities, and local health departments. It is not possible to determine the extent of the fiscal impact at this time.

Fiscal Analyst: L. Nacionales-Tafoya

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.